84 SECTION J – QUALITY MANAGEMENT

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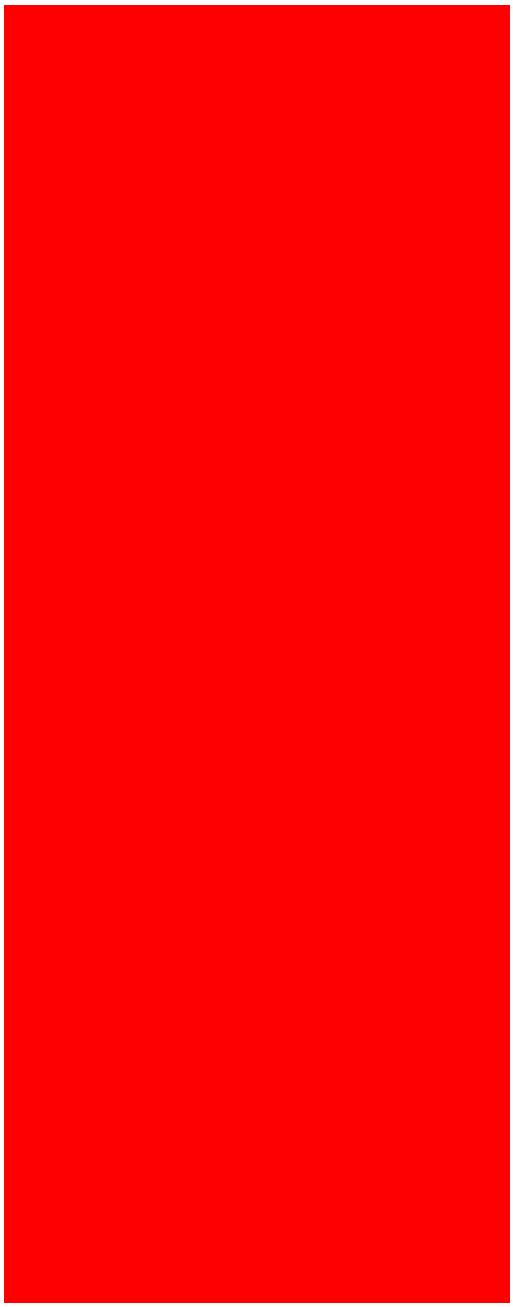


Section J: Quality Management (Section §14 of RFP)

J.1 Document experience in other States to positively impact the healthcare status of Medicaid and or CHIP populations. Examples of areas of interest include, but are not limited to the following:

- **Management of high risk pregnancy**
- **Reductions in low birth weight babies**
- **Pediatric Obesity (children under the age of 19)**
- **Reduction of inappropriate utilization of emergent services**
- **EPSDT**
- **Children with special health care needs**
- **Asthma**
- **Diabetes**
- **Cardiovascular diseases**
- **Case management**
- **Reduction in racial and ethnic health care disparities to improve health status**
- **Hospital readmissions and avoidable hospitalizations**

Aetna Better Health®, together with its affiliates, has more than a 25 year history of positively impacting the healthcare status and quality of life of Medicaid and CHIP members we serve. Our standard operating procedure is to implement innovative programs for care coordination, disease management, implementing patient-centered medical homes, and improving access to care in our Medicaid managed care programs in ten (10) states. Aetna Better Health's top priority is to provide each member with the right service, at the right time, at the right level of care, and our experience with these interventions demonstrates the effectiveness of this priority.

Documented Experience

Aetna Better Health and its affiliates have a history of concrete and documented experience that has positively impacted the health care status of our Medicaid and CHIP members. Building on our experience and the excellence of our existing programs, we will continue our best practices and apply our experience in developing and implementing care management programs based on our philosophy that quality health care is a priority and an imperative. Below we present specific information and data that demonstrates our commitment to, and success in, managing health care delivery related to the Department of Health and Hospital's (DHH) identified areas of interest.

Aetna Better Health is proud to present the following summary explanations as examples of our initiatives to improve health outcomes and create effective, efficient service delivery systems.

Area of Interest	State(s) Example	Populations (TANF, ABD, SCHIP)	Positive Impacts
Management of High Risk Pregnancy	Missouri Medicaid	TANF	Our targeted member outreach program resulted in 95.83% of pregnant members receiving timely prenatal care services as measured by HEDIS®[1]. This rate exceeded the NCQA 90th percentile (92.7%).
Reductions in Low Birth Weight Babies	Missouri Medicaid	TANF	Our integrated care management (ICM) for high-risk pregnant members resulted in a 20% reduction in low birth weight babies.
Pediatric Obesity (Children under the age of 19)	Delaware Medicaid	TANF, CHIP	Our We can! public outreach campaign to increase physical activity resulted in a 21% improvement in the likelihood of children being physically active.
Reduction of Inappropriate Utilization of Emergent Services	All Aetna Better Health Affiliated Health Plans	ABD, TANF, CHIP	ED visits, along with PMPM expenditures were consistently lower for members enrolled in our disease management program.
EPSDT	Maryland Medicaid	TANF, ABD, CHIP	2009 HEDIS rates exceeded the NCQA 90th percentile (82.48%) for well-child visits for children aged 3-6 years at 85.67%.
Children with Special Health Care Needs	Arizona Medicaid	ABD, TANF, CHIP	Through our ICM program children with special health care needs receive enhanced care coordination services, improved access to specialty care services, and access to a patient-centered medical home.
Asthma	Missouri Medicaid	TANF, CHIP	46% reduction in emergency room visits per member per year and a reduction of $146 in costs per member per month.
Diabetes	Delaware Medicaid	TANF, CHIP	Statistically significant Increase in the number of members receiving Hba1c tests from 71.1 percent to 82.8 percent ($p < 0.05$) as measured by HEDIS.

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance.

Area of Interest	State(s) Example	Populations (TANF, ABD, SCHIP)	Positive Impacts
Cardiovascular Diseases	Delaware Medicaid	TANF, CHIP	38% increase in Primary Care Provider (PCP) visits, cost savings of $113,050.80 for the Medicaid program (85% decrease), an 82% reduction in inpatient admissions, and a 75% reduction in ED visits for members with CHF.
Case Management	Aetna Better Health Affiliated Plans	ABD, TANF, CHIP	Hospital length of stay has continued to decline from 3 days in 2006 to 2.4 days in 2010..
Reduction in Racial and Ethnic Health Care Disparities to Improve Health Status	Texas	TANF, CHIP	100% of our Member Services representatives are bilingual and work at home in the local communities we serve.
Hospital Readmissions and Avoidable Hospitalizations	Aetna Better Health Affiliated Plans	TANF, CHIP, ABD	Aetna Better Health's Impactable Admissions Program (IAP) achieved an overall 10 percent reduction in avoidable admissions (ranging from 3 percent to 21 percent across eight health plans), and a 2 percent reduction in re-admissions, resulting in both significant savings and improvements in quality of care.

Aetna Better Health employs a variety of proven approaches and technologies to positively affect the health status of our members. We coordinate and facilitate the use of these approaches and technologies to continually improve our managed care programs. In the following sections, we highlight a few of our programs used to monitor, track or report on improving the healthcare status, quality, accessibility and effectiveness of covered services.

Navigating the Health Care Delivery System

Navigating the health care delivery system in a managed care environment is a complicated task, due to the size and scope of the system alone. Medicaid and CHIP members experience additional challenges related to poor understanding of health issues or required treatment, the complexity of their health conditions, as well as the impact of inadequate social support or transportation necessary to receive care. We recognize that our members who have the most difficulty navigating the systems are those who: 1) have complex, co-morbid physical and behavioral health or substance abuse conditions; 2) face difficult or unstable social situations; 3) have fewer internal or external resources; and 4) have reduced health literacy.

Due to our long-standing relationship with Medicaid and CHIP members, Aetna Better Health brings to the Louisiana CCN managed care programs and strategies designed to provide

assistance with communication between members and providers, assessment of needs, coordination of care and referral to critical services. Identification occurs through external and internal avenues described below:

- External identification may come through provider requests, prior authorization requests, a member or member's parent/caregiver, and community-based service referrals
- Internal identification primarily occurs through member contact with our Member Services Department, Aetna Better Health Provider Services, Disease Management (DM) Program, concurrent review nurses, Integrated Care Management (ICM), or Quality Management Department.

Aetna Better Health's promotion, outreach, and monitoring programs are specifically designed to assist members, their family, and their caregivers in navigating the health care delivery system. A key component in these programs is the member's PCP or Patient-Centered Medical Home (PCMH). In addition, we have active promotion and outreach programs that include, but are not limited to:

- EPSDT
- Maternal and child health
- Disease management (including Asthma)
- Children with special health care needs
- Dental
- Prenatal and postpartum care
- Prevention and Wellness
- HEDIS

At one time or another, all members may need support in negotiating the health care delivery system. The amount of support required depends upon the member's level and intensity of need, readiness for change, cultural experience and values, health literacy and life stressors. We know that racial and ethnic disparities in care have a real affect on a member's use of covered services. Ethnic, cultural, and linguistically diverse individuals and groups face many challenges and barriers accessing, navigating and taking advantage of the health delivery system. Aetna Better Health provides one or more of the following types of assistance to our members:

- Assistance finding a PCP, specialist, making appointments and identifying other internal and external resources
- Education about their conditions and health coaching
- Empowerment to take charge of their situation to make them more self sufficient in managing their conditions
- Interventions to prevent the progression of disease or reduce complications
- Oversight of their progress and monitoring to assure that new needs have not arisen or that their conditions are improving

Our assistance includes helping members, and using translation services and our understanding of racial and ethnic disparities in care, to learn and understand:

- What services and treatment are needed and how to use their benefits and make requests
- How to appropriately access services and treatment
- Types of decisions (e.g., regarding medically necessary treatments, care plans, advance directives) and how they are made
- Types of providers (i.e., in-network, out-of-network)

Aetna Better Health's personnel use an array of tools and strategies to provide member support and assistance that ranges from holistic approaches to member-centered, one-on-one interaction tailored for the individual member's cultural, physical, behavioral and social needs. Every member has access to these supports, but we focus on members with:

- Complex and intense physical health conditions
- Less stable social situations coupled with multiple, high and long standing stressors
- Fewer internal and external resources to meet needs
- Low health care literacy

Quality Assessment and Performance Improvement Program

The foundation of our comprehensive Quality Assessment and Performance Improvement Program (QAPI) is continuous quality improvement techniques. Our QAPI Program includes, but is not limited to, approaches to assess a) members' care, b) delivery systems, and c) member/provider satisfaction while optimizing health outcomes and managing costs. In addition, we designed our program to support DHH's quality improvement strategy, and to be in full compliance with state and federal QAPI Program standards and guidelines.

Aetna Better Health views the QAPI Program as a health plan-wide endeavor and our management team uses an integrated and collaborative approach that involves each functional area, including the Quality Management, Utilization Management (prior authorization, concurrent review, retrospective review), Case Management (integrated care management), Grievance and Appeals, Provider Services, Informatics, Actuarial Services, Member Services and Claims Departments. Our Chief Medical Officer (CMO) has been assigned the specific responsibility for overseeing our QAPI Program. Supporting our CMO in this effort is our Quality Management Department and our formal medical committees (e.g., the Quality Management Oversight Committee (QMOC), Quality Management/Utilization Management (QM/UM) Committee, Credentialing and Performance Committee (CPC), Health Education/Member Advisory Committee (HEMAC), Compliance Committee, and Service Improvement Committee (SIC)) as well as ad hoc work groups formed to address specific quality assessment and improvement issues. These committees, with their cross-functional membership, play a lead role in setting our strategic direction and in assessing our performance. A key element is that we disseminate root-cause analysis and lessons learned throughout the health plan and this analysis forms the basis for process improvement activities. In addition, Aetna Better Health establishes partnerships with stakeholders in the health care and social services communities, supports several community-based health improvement initiatives, and actively solicits public input on our QAPI Program.

Member Identification

An important element of our programs to improve healthcare status of our members is the identification of members at risk of or in need of care coordination because of their disease state. It is our standard operating procedure to gather and analyze accurate, timely, complete, and relevant information about the utilization patterns of members. Utilization pattern data are instrumental in the effective identification of members at risk of or in an active disease state. This will be a management focus of Aetna Better Health because this information is vital to our ability to monitor and report on the status of our members. We have continually strengthened and improved our ability to gather, analyze, monitor/evaluate, and report utilization data to facilitate the delivery of appropriate care and services to our members. Throughout our process of collecting and managing utilization data we protect the privacy of our members and the security of our members' protected health information (PHI).

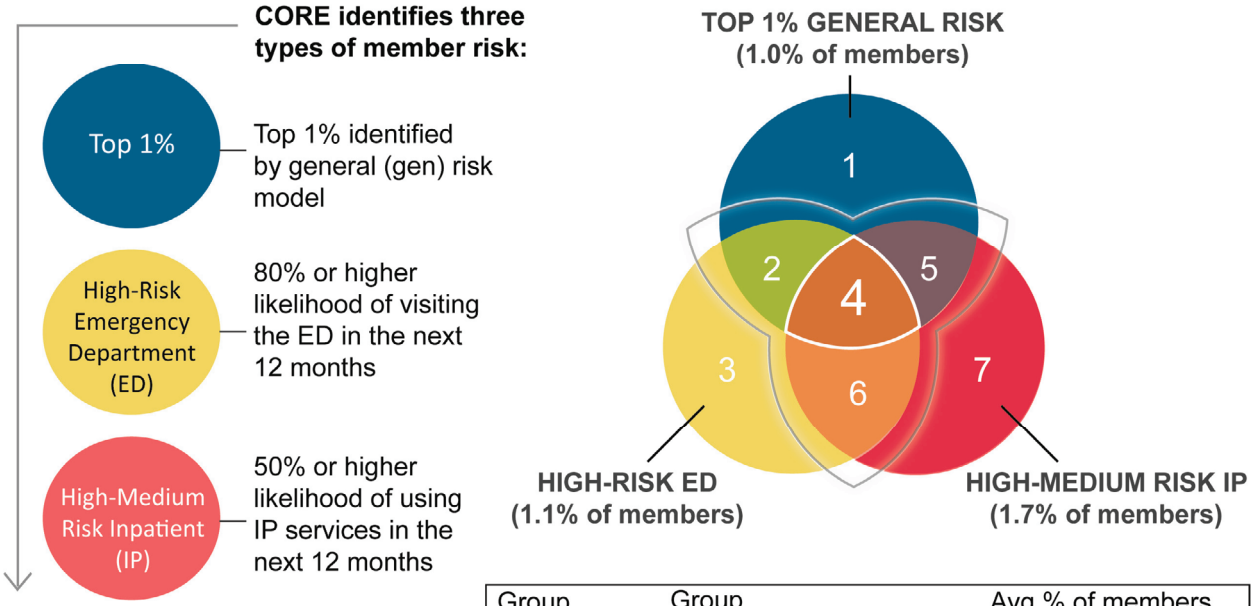
Aetna Better Health gathers, analyzes, evaluates/monitors, and reports utilization data to effectively manage and deliver medically necessary and covered services in the amount, intensity, and duration necessary to achieve improved health outcomes for our members across the continuum of care (from prevention to the end of life). Our goal is that the members receive the right service, at the right time, and at the right level of care/setting. We consider the collection of accurate, timely, and complete utilization data to be pivotal to our success to facilitate the delivery of appropriate care and services to our members. One of our major sources of utilization data is claims and encounters data. These data are our most significant source of information for the evaluation/monitoring and reporting of utilization patterns.

We augment claims data with prior authorization (PA) information, from both our PA Department and information from our Integrated Care Management (ICM). One example of the value of PA information is our early warning respiratory report to indicate an increase in inpatient utilization that may be due to a flu outbreak. Both the claims data and encounters are treated the same by our Actuarial Services Data Base (ASDB) - our claims warehouse. ASDB supports our reporting and analytical needs, such as our multidimensional predictive modeling and statistical outlier analysis. ASBD includes eligibility, provider, prior authorization, pharmacy, and claims data and serves as a key data source for medical management. Analyst from Informatics Department use the proprietary Actuarial Analytics Web Portal (AAWeb), an interactive interface, as a point-and-click query tool to access reports; drill down into data and export information from ASDB. For instance, AAWeb can generate customized analyses to identify favorable and unfavorable cost and utilization trends, measure performance against key benchmarks, and review summary information. It is a powerful tool that provides our leadership with access to member/provider cost and utilization trends.

Aetna Better Health uses a standard suite of 14 utilization management reports that provides our leadership with a comprehensive set of information to examine utilization patterns and trends. Data from these reports are analyzed by our weekly inter-department utilization management work group, led by our CMO, to determine potential over/under utilization. Of these 14 reports, there are six (6) key utilization reports that represent the core of the data we analyze. These reports are: 1) Category of Expense (COE); 2) PCP Initiative Report; 3) Inpatient Cost Report; 4) Pharmacy Utilization Report; 5) Inpatient Census Report; and 6) ED Cost Report.

In addition to these reports Aetna Better Health uses our Consolidated Outreach and Risk Evaluation (CORE) tool to identify members at risk of or in an active disease state. This tool uses historical claims data to prospectively identify members who are at high risk of having adverse outcome in the near future. Our predictive modeling tool includes our proprietary predictive modeling software that uses medical and pharmacy claims data to predict a member's future risk probability. The outcome of this analysis feeds our comprehensive Consolidated Outreach and Risk Evaluation or CORE model. The CORE identifies three types of risk: 1) high risk Emergency Department (ED), defined as an 80 percent or higher likelihood of visiting the ED in the next 12 months; 2) high-medium risk inpatient (IP), defined as a 50 percent or higher likelihood of using IP services in the next 12 months; and 3) the top one percent of members identified as high-risk. Because there is significant overlap between these three risk groups, we represent these groups visually as a Venn diagrams (see diagram below).

Aetna Medicaid's Consolidated Outreach and Risk Evaluation (CORE) tool identifies members who will benefit most from our Integrated Care Management program. This tool uses acute care, pharmacy and long-term care (LTC) claims data to identify members at high risk for adverse future health outcomes.



Identifying highest risk members

This diagram shows three risk categories. The areas of overlap represent members at high risk (groups 2, 4, 5 and 6) for adverse health outcomes. Group 4 represents members at the highest risk, falling into all three risk categories.

Group #	Group name	Avg.% of members for typical health plan
1	Top 1% Gen risk ONLY	0.6%
2	Top 1% Gen risk / High-risk ED	<0.1%
3	High-risk ED ONLY	0.3%
4	High-med risk IP/Top 1% Gen risk/High-risk ED	0.2%
5	Top 1% Gen risk / High-med risk IP	0.2%
6	High-risk ED / High-med risk IP	0.6%
7	High-med risk IP ONLY	0.7%
Percentage of members not in CORE:		97.4%

Note: Percentages may not add up to 100% due to rounding

Assessment, Care Management

The reports and CORE process identified above are key elements in the identification of members at risk of or in an active disease state. In addition, we often identify or confirm our identification using system tools, through internal referral (PA, Concurrent Review, Case Manager), Primary Care Physician/Patient-Centered Medical Home (PCP/PCMH), self-referral and referrals from care givers. Our process, for those members who will be enrolled in our Integrated Care Management (ICM) includes an assessment of the member. The ICM model is a natural extension of our commitment to improve our members' health outcomes, enhancing their quality of life and reducing racial and ethnic health disparities by providing needed care in the most appropriate setting.

Through ICM we assess the following areas to design of the member's healthcare plan of care:

1) Clinical history and utilization
2) Member's functional level
3) Living environment and support mechanisms
4) Medications
5) Member's self-care
6) Providers and other services
7) Perinatal

Our assessment of these areas serves as the basis for the case formulation and case plan.

Working closely with the member, the member's caregiver and PCP, we use the plan of care as a roadmap to help guide the member through the fragmented health care system to improve access and coordination of medically necessary and covered services. The ICM model enhances the member's experience by focusing on the following guiding principles:

- *Move from disease focus to member focus*: Evaluating every member for physical, behavioral, and social risks to their current and future health. Holistically integrating and coordinating healthcare services that support individual members' physical and social needs.
- *Identify and employ the most effective intensity of evidence-based, covered systems and services*: Facilitating access to a continuum of services based on the intensity and complexity of each member's needs
- *Employ behavioral engagement for change*: Using a case manager as the single point of contact to engage each member, as well as their responsible parties, in the development of an approach to address the member's physical and social needs to promote resiliency
- *Team with the member and their responsible parties and PCP to enhance care outcomes*: Working as an interdisciplinary team that emphasizes core competencies in physical health within a systems framework.

Aetna Better Health will apply our programs/protocols, technology solutions and experience in improving member health outcomes to the Louisiana Medicaid Coordinated Care Network (CCN) program. We have developed innovative programs to improve access to preventive care for children and adults, while simultaneously reducing emergency room visits, avoidable hospital

admissions, and readmissions. Aetna Better Health shares the state of Louisiana's vision for a Medicaid program that provides effective, efficient services that result in: better health outcomes, promotion of healthy behaviors, a reduction in the rate of avoidable hospital stays and readmissions, a patient-centered medical home for members, increased quality of care, and member access to the right kind of care, in the right place at the right time.

AREA OF INTEREST 1: MANAGEMENT OF HIGH RISK PREGNANCY

As pregnancy is one of the primary eligibility categories for many of our members, Aetna Better Health has a comprehensive program to identify, track and coordinate the care of pregnant members with a focus on attaining positive health outcomes for both the mother and her child. Our goal is to provide the delivery of timely prenatal care in accordance with recommended periodicity schedules, reduce the incidence of poor birth outcomes and low birth weight infants and improve the rate of postpartum visits. Aetna Better Health's vast experience in managing members with high risk pregnancies and improving birth outcomes supports Louisiana goal to improve birth outcomes and reduce its infant mortality rate.

Aetna Better Health has established a comprehensive perinatal and postpartum care program to identify, track and coordinate the care of pregnant members, with a focus on attaining positive health outcomes for both the mother and her newborn. Our Perinatal and Postpartum Case Management Program provides case management to all pregnant members from their date of enrollment (new member) or pregnancy confirmation (existing members) through the 60-day postpartum period. Our overall goal is to assure that these individuals have access to high quality, cost effective prenatal care and timely identification and intervention for postpartum concerns.

We understand that an expectant mother who receives prenatal care is 75 percent more likely to deliver a healthy baby. For this reason, we strive to identify and establish relationships with expectant mothers as soon as possible. To this end, Aetna Better Health works with other health plans and state agencies to enroll pregnant members into managed care and establish physician care as early as possible. Consistent and timely postpartum care supports early identification and intervention for postpartum risks such as postpartum depression, breastfeeding problems, mother-baby bonding issues and family planning.

Process for Identifying Pregnant Members

Aetna Better Health understands that early identification is the first step toward improving birth outcomes. Early identification and case management intervention are critical to our program.

Strategies we use to identify and refer pregnant members for perinatal case management include, but are not limited to, the following:

- All plan personnel understand and are educated about our high risk perinatal case management program. Any contact with plan personnel can generate a referral.
- Member Services representatives are a frequent first contact point. They refer members who believe they are pregnant or who have questions about maternity-related services.

- Concurrent review/prior authorization personnel refer members who are or may be pregnant when they identify them in an inpatient setting or through pregnancy-related prior authorization requests.
- PCPs are required to refer members who are or may be pregnant.
- Fetal medicine/perinatologists refer pregnant women who are enrolled in our health plan.
- The member handbook and our Web site encourage pregnant members to self-refer. They may use the toll-free number or our Web site to contact the plan.
- Review of internal reports, such as Emergency Department utilization reports, to identify pregnant members accessing services through the ED.

Aetna Better Health's Perinatal Case Management Program

The focus points of Aetna Better Health's perinatal services include:

- **Early identification** - Identify pregnant members as early as possible through collaborative efforts with internal and external resources to improve birth outcomes.
- **Ongoing support and interventions** - Follow each member throughout their pregnancy and the 60-day postpartum period.
- **Coordination with community support services** - Refer and assist members to access community resources, such as WIC, school and community-based teen pregnancy programs, mentoring programs for pregnant adolescents and depression counseling services.
- **Improved birth outcomes** - Provide case management and care coordination services and assure that prenatal and postpartum interventions are effective and timely

Our program consists of the following fundamental components:

- **Identify risk factors** - Assess pregnant women to identify any risk factors and conduct reassessments at each trimester through the pregnancy.
- **Education** - Provide appropriate educational materials and respond quickly to any questions or concerns that the member may have. Inform members about prenatal and infant and child care classes available in the community.
- **Access to community services** - Provide information about and assistance to obtain available community services and programs.
- **Coordination of care for identified risk issues** -
  - Assist with referrals for perinatologists and other specialty providers
  - Refer for screening, counseling and appropriate treatment for HIV and other sexually transmitted diseases (STDs).
  - Referral for domestic violence services
  - Assess for behavioral and substance abuse issues and enrollment into behavioral health services
  - Encourage postpartum follow-up visits and referrals
- **Identify and resolve barriers to care** - Collect and track information about each member's pregnancy, birth outcomes, case management interventions, compliance with scheduling and

keeping appointments and provide any needed assistance with transportation or other barriers to care.

- **Quality network providers** - Maintain a diverse network of maternity health care professionals to meet members' needs and assure members receive comprehensive prenatal and postpartum care from qualified, culturally competent maternity care providers.
- **Community outreach** - Conduct member and community outreach and education to "spread the word" about the benefits of early and comprehensive prenatal and postpartum care and the services that are readily available through our health plan.
- **Holistic culturally sensitive care** - Provide special consideration for:
  - Pregnant adolescent members
  - Members with a history of high risk pregnancies (such as previous low birth weight babies)
  - Members with comorbidities (e.g., Diabetes, HIV/AIDS)
  - Pregnant members with a history of substance abuse or mental illness
  - Members with limited English proficiency, auditory disabilities, low health literacy or other potential barriers to care

Aetna Better Health's web-based care management business application (Dynamo™) provides perinatal case managers with the ability to track comprehensive information about each member enrolled in our Perinatal and Postpartum Case Management Program, including:

- Outreach activities and contacts with the member
- Initial and ongoing assessments
- Interventions and educational activities
- Links to, and recommendations for, community services and resources
- Appointments with maternity health care professionals
- Pregnancy outcomes

One of or web-based care management business application (Dynamo™) innovative features is a perinatal risk assessment questionnaire that can identify a member's immediate needs, past and current obstetrical and medical history, and current behavioral or social risks, including substance abuse and domestic violence. The identified risks drive the design of the individualized care plan with interventions specific to each member's needs.

High Risk Perinatal Case Management

Aetna Better Health's High Risk Perinatal and Postpartum Case Management Programs are designed to assess for high risk maternal and fetal issues and coordinate and manage the care of women with high risk pregnancies. We recognize that each member's pregnancy is a unique experience and many behavioral, social and medical factors can result in a high risk pregnancy. Examples of high-risk issues addressed in our case management program:

- High risk medical or behavioral health conditions and comorbidities (current or history of) such as:
  - History of Preterm Labor or development of Preterm Labor

  - Asthma
  - Diabetes
  - Sickle Cell Anemia
  - Sexually Transmitted Diseases
  - Depression or history of postpartum Depression
  - Serious mental illness
  - Multiple gestation
  - Short spacing between births of < 18 months
  - Hypertension
  - Gestational Diabetes
  - Age (e.g., younger than age 15, older than age 35)
- Social Stressors such as:
  - Homelessness
  - Domestic violence
  - Single parent
  - Teen parent
- Fetal factors such as:
  - Exposure to infections, damaging medications and/or addictive substances
  - Congenital Anomalies

Our goal is to improve health outcomes for the mother and her newborn. Women with high risk pregnancies may require monitoring and interventions that closely track conditions, identify complications and evaluate their impact on the baby. These may include additional provider visits, referrals to Perinatologists/Maternal Fetal Medicine specialists, other specialists, amniocentesis and fetal monitoring.

Once the pregnant member is identified for case management services, Aetna Better Health's perinatal case managers work closely with all high risk members to develop a customized care plan that includes: 1) providing authorization of additional specialists services and/or testing, as needed; 2) resolving barriers to care such as transportation needs; 3) providing culturally and linguistically appropriate materials for mother and family education; 4) serving as a center point for communication among all involved parties and identifying community resources to assist members; 5) enrolling member's with a history of drug/alcohol abuse the participant in a treatment program and see that these women go to the "front of the line" for treatment; 6) identifying members with a history of prior delivery requiring NICU services, identify the reason and determine if it is repeatable and/or preventable; and 7) providing members who are anemic (a marker for poor nutrition) with iron supplements, conduct an in-depth review of eating habits and diet and provide an early referral to Women, Infants and Children program.

Focused Initiatives

Prenatal Appointment Compliance Tool

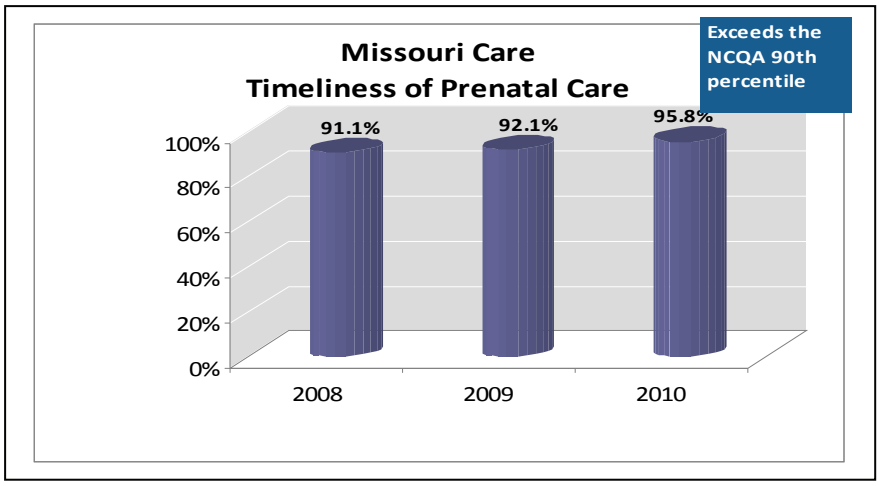
Aetna Better Health has also collaborated with the Prenatal Appointment Compliance Tool (PACT) program to provide outreach and education to pregnant members. PACT increases utilization of prenatal care by texting identified pregnant members with educational information and prenatal care reminders from Aetna Better Health's CM/UM/QM and other medical management personnel. Similar to the Text4Baby program, PACT provides valuable information to pregnant members who may not have ready access to health education materials as well as an efficient mechanism for providing member outreach. As a result, pregnant members are more likely to access prenatal care and give birth to health babies.

Comprehensive Substance Abuse Treatment and Referral (CSTAR)

Our Missouri affiliate, Missouri Care maintains a unique partnership to provide pregnant women with substance abuse issues specialized services. Missouri Care's case managers refer all pregnant woman identified with a substance abuse problem to a specialized Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) Program for Women. Pregnant women are also be referred by their PCP or primary care obstetricians. CSTAR offers clinical services, living arrangements and support services tailored for each member, including screening, assessment, diagnosis and the development of an individual plan of care. CSTAR also provides recovery and outpatient services in the member's community.

Outcomes

As demonstrated in the graph below, Missouri Care's focus on outreaching and educating members on prenatal care results in this plan performing consistently well on the HEDIS measure related to timeliness of prenatal care, exceeding the NCQA 90th percentile.

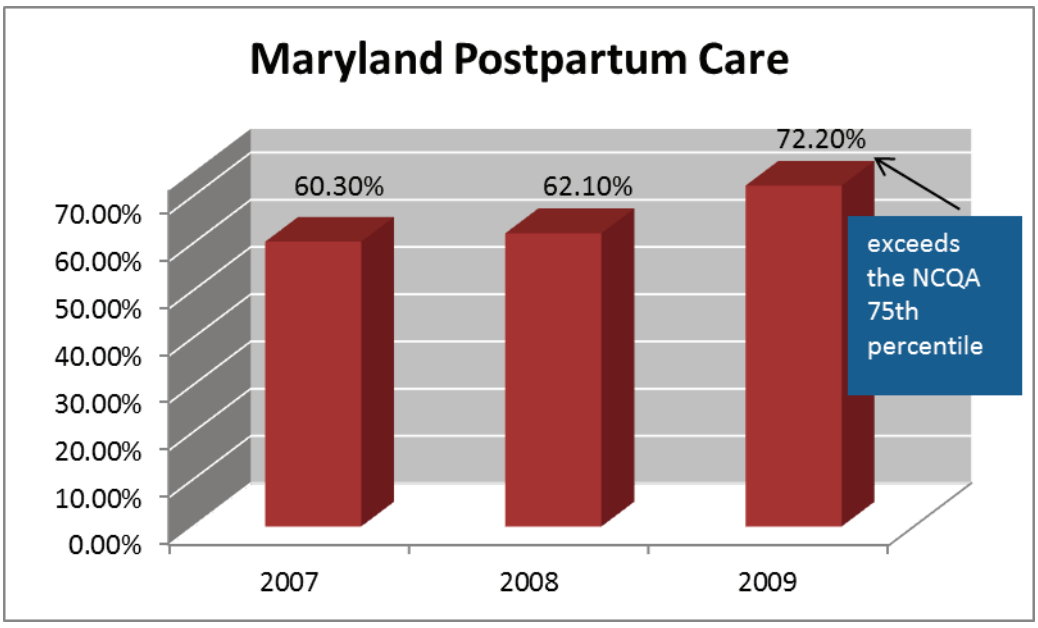


Postpartum Care

Aetna Better Health recognizes that the continuum of care for pregnant women extends through the postpartum period. Timely postpartum care is an essential component of promoting well-being for mothers and babies. The postpartum visit is an opportunity to identify physical and mental health issues, such as postpartum depression, as well as feeding and bonding issues. It is the optimal time for family planning to occur. Our Case Management Program supports this important health step by:

- **Follow-up case management:** Members enrolled in perinatal case management receive follow-up calls and assessments. These assessments are intended to identify potential maternal physical and mental health issues and assessment basics for the newborn.
- **Education:** All members enrolled in case management are educated throughout the case management period about the importance of postpartum care.
- **Educational Materials:** All new mothers receive the "*You and Your New Baby Book"* which contains helpful information for new moms and stresses the importance of postpartum care.
- **Provider Education:** Postpartum care is reimbursed under the OB Global Authorization and providers are encouraged to stress the importance of postpartum care to their patients.

Aetna Better Health's perinatal case management program has resulted in positive outcomes for our members. As demonstrated in the graph below, our Maryland plan exceeds the NCQA 75th percentile on HEDIS rates for postpartum care.



AREA OF INTEREST 2: LOW BIRTH WEIGHT BABIES

In addition to its perinatal case management and PACT programs, Aetna Better Health and its affiliated health plans have developed initiatives to reduce the number of low birth weight babies born to our members to improve member health outcomes. For example, Missouri Care, an Aetna Better Health affiliated Medicaid plan, implemented a clinical initiative to improve prenatal care that resulted in a 20% reduction in low birth weight babies.

Missouri Care identifies members at high risk of a premature delivery or other complications that might require their baby to be admitted to a Neonatal Intensive Care Unit (NICU) and offers them clinical case management services for the duration of the pregnancy. Case management services include assessment, coordination of care, and follow-up on provider appointments, at least one prenatal home health visit and other supportive services.

Missouri Care also contracted with a home health agency to provide home visits to pregnant members identified as having high risk factors. All identified members are offered a minimum of one prenatal and one post-partum home visit. Additional prenatal home visits are authorized based on the results of the home visit assessment. The goal of the prenatal home visit is to increase the member's access to health care services and provide education about pregnancy, nutrition, risks, and the importance of follow-up care. The home health nurse builds a relationship with the member and became a source of knowledge and support to the member throughout her pregnancy.

Missouri Care's (an Aetna Better Health affiliate) prenatal care program resulted in a 20% reduction in low birth weight babies.

Missouri Care further expanded this initiative to include a teen pregnancy Case Manager who was funded through a grant developed in partnership with several community agencies. This Case Manager monitors the Plan of Care for pregnant teens, serves as a liaison to the medical community, and networks with teens not attached to any educational setting. Home visits, along with group opportunities, are provided during the prenatal period and until the child is two years of age.

AREA OF INTEREST 3: PEDIATRIC OBESITY

Aetna Better Health has been on the forefront of efforts to address America's childhood obesity crisis in our Medicaid and SCHIP managed care programs across the nation. We have incorporated members with obesity and obesity-related conditions into our disease management programs, funded community initiatives, and partnered with national organizations to improve health outcomes for members with obesity. For example, our Aetna Better Health affiliated plan in Delaware, Delaware Physicians Care, Inc (DPCI) implemented a pilot project based on the "CATCH Kids, We Can!" initiative of the National Institutes of Health (NIH). We Can! (i.e., Ways to Enhance Children's Activity & Nutrition) is a national public education outreach program designed to help children 8–13 years old stay at a healthy weight through improved food choices, increased physical activity and reduced screen time (i.e., TV, computers). We Can! is unique because it provides practical tips and materials to parents and families in home and community settings.

The mission of the DPCI obesity prevention project is to assist in bringing together existing community resources and assets to improve the overall quality of life for its members and their communities. To that end, DPCI partners with health promotion organizations to provide community members with information about nutrition, physical activity, and maintaining a healthy weight in order to address the impact of obesity on families.

In 2007, DPCI developed a memorandum of understanding to incorporate the We Can! program into its obesity prevention project to address increasing obesity rates in the state of Delaware. DPCI then initiated informal partnerships with community organizations, expanded trainings to community staff on We Can! Lesson plans, and curricula, and donated CATCH kids club materials to others in the community working on similar issues. DPCI also partnered with the University of Delaware to engage interns in the execution of the We Can! program, using a "train the trainer" model to instruct the interns on how to sustain the initiative going forward and donated CATCH Kids fitness equipment to community organizations.

DPCI was a gold sponsor at the 2009 Martin Luther King Day celebration in Wilmington, Delaware, hosting the Wellness Zone, which provided interactive health, nutrition and educational activities for families. This event marked the start of the "We Can! Make Healthier Choices" obesity prevention awareness campaign. DPCI also provided We Can! Educational support and lesson plans to four Boys and Girls Clubs in Delaware and launched an obesity prevention website that provides audiences with a comprehensive list of health-related national programs, highlighting the We Can! Program and its resources.

DPCI's organizational goals in the area of childhood obesity continue to align with We Can! program goals. Through this collaborative partnership, DPCI is continuing to review policies and programming that target obesity prevention.

Outcomes

Through the We Can! Partnership, DPCI promoted healthy behaviors through member outreach and education programs. As a result, participants showed increased rates of physical activity, increased rates of making healthy food choices, and reduced screen time rate. The pilot program proved so effective in increasing physical activity among the participants (the likeliness to be

physically active increased by 21 percent) as well as improving their nutritional knowledge that was expanded to three (3) additional sites in 2008.

Going forward, Aetna Better Health's goal is to continue to expand our efforts in addressing childhood obesity based on identified best practices from the many pilot initiatives and projects operating around the country. Our experience tells us that continuous follow-up is essential to the long term success of these programs and greatly increases our ability to achieve improved physical fitness, nutritionally sound eating habits and the maintenance of a healthy weight among our nation's children.

AREA OF INTEREST 4: INAPPROPRIATE USE OF EMERGENCY SERVICES

Aetna Better Health supports access to services along the health care continuum based upon the member's needs. We know that the overall health status of the member can be enhanced through the establishment of a health care home versus the episodic care available in an Emergency Department (ED). To that end, we have developed a comprehensive array of programs to reduce inappropriate use of ED services, including member and provider education, expansion of the network, frequent monitoring of utilization data, performance improvement activities, integrated care management, and our disease management program.

To see that our members have access to needed services, including urgent care and emergency services, on a 24-hour-a-day, 7-day-a-week, 365 days per year basis, Aetna Better Health requires our contracted network providers to be available at all times to the members under their care. In addition, we have a 24-hour-a-day, 7-day-a-week advice line (Informed Health Line) available to our members.

Aetna Better Health closely monitors trends in ED utilization and implements appropriate interventions to address identified issues. In addition, our PCPs, per contract, are not permitted to "sign out" to the ED, or leave outgoing messages on their phone lines or with their answering services instructing our members to go the Emergency Department for after-hours care.

Emergency Department (ED) Utilization

We have designed our comprehensive approach for evaluating and managing ED utilization to identify: 1) providers or members who may be abusing ED services; 2) members who may be in need of case or disease management intervention; and 3) gaps in our network. Our overriding management goal is to provide the right service, at the right place/location and at the lowest effective cost. We employ a variety of strategies to monitor and address Emergency Department utilization, including:

- Reviewing claims and other relevant data such as ED logs to monitor utilization patterns
- Educating providers and members about the appropriate use of the ED and alternatives to ED care
- Making referrals to case management or disease management to assist the member with access to appropriate resources
- Educating members on the availability of behavioral health crisis services

Monitoring ED Utilization

On a regular basis, Aetna Better Health's medical management personnel generate and review the following reports:

- High-utilizing members (members who are very likely to use the ED in the next 12 months using our predictive model)
- ED visits by member and by PCP
- ED visits by referring PCP groups
- ED visits by diagnosis: The top 10 diagnoses for members presenting to emergency departments include:

- Upper respiratory infection
- Otitis media
- Pharyngitis
- Viral infection
- Gastroenteritis
- Abdominal pain
- Fever
- Bronchitis
- Headache
- Urinary tract infection

Aetna Better Health's personnel use these reports to track and trend information and identify potential over-utilization patterns, including:

- Identifying providers who may be influencing inappropriate use of ED services
- Identifying members who are high utilizers of ED services for non-emergent conditions and situations
- Identifying hospitals that have high utilization such as regular follow-up arranged through the ED

High utilizing members are referred to case management, receive outreach at least two times a month, and receive health education. We also contact PCPs to discuss barriers to access, care planning and ongoing education.

Member and Provider Education

Aetna Better Health has implemented a number of educational initiatives to address inappropriate ED utilization, support the medical home concept and promote consistent quality of care for our members. We do this through outreach to members and providers to include: one-to-one education and newsletters, as well as through our website.

Interventions for Providers

Aetna Better Health works collaboratively with providers to address issues that may affect ED utilization, such as prescribing patterns (e.g., Asthma controller and rescue medications). Our medical management personnel, in collaboration with provider relations personnel, may conduct educational and outreach sessions for either an individual or group of providers who we have identified as contributing to excessive ED utilization.

Aetna Better Health also proactively reaches out to providers with strategies for improving access for their patients in the office or clinic setting rather than the ED. For example, in one family medicine clinic with a pattern of excessive ED utilization, the implementation of an open-access appointment system resulted in a 10 percent reduction in ED visits and the no-show rate for the clinic decreased from over 30 percent to 15 percent.

Interventions for Members

Aetna Better Health's New Member Welcome Packet, Welcome Call, Member Newsletters, Web site and other member information materials specifically include information encouraging the appropriate use of emergency rooms. Additional interventions include:

- Individual counseling and education on appropriate use of the ED
- Assisting members in selecting an alternative PCP, if appropriate
- Screening members for unmet behavioral health needs (a frequent driver of ED over-utilization) and working with members to navigate the system and gain access to needed services
- Educating members to go to the nearest urgent care or emergency room if they have a true emergency in our materials and during all interactions

Network Adequacy

Aetna Better Health's network development personnel continuously monitor the adequacy of our provider network (PCP and specialty) to provide accessibility and availability of needed services for members, including emergency and urgent care services, and identify opportunities to enhance our network on an ongoing basis. Our network monitoring activities include, but are not limited to, the following:

- GeoAccess studies
- Member complaints and grievances and appeals and provider complaints and appeals
- Member satisfaction survey data
- Provider profiling
- Analysis of services rendered by out-of-network providers

We review data from these sources quarterly and develop and implement interventions to address identified deficiencies.

Performance Improvement Activities

Aetna Better Health has implemented an array of initiatives and activities to promote the appropriate use of emergency services, including, but not limited to:

- Auditing providers' after-hour telephone answering machine instructions to determine whether their messages are appropriate (e.g., member is not immediately directed to the Emergency Department) and providing additional education to providers who do make such referrals
- Using data from the CORE to identify frequent users (members with three or more ED visits in one month). Once identified, we send educational letters, refer identified members to case management and conduct outreach activities to identify and remove barriers to care
- Educating members about the appropriate use of the ED and the availability of urgent care centers and the Informed Health Line through the Member Handbook, member newsletters, our Health Plan Web site and during telephone contact with members
- Notifying providers about members on their panel who are inappropriately using the ED so that they can assist us in redirecting these members to more appropriate resources

- Identifying members with inappropriate and unsafe pharmacy utilization and referring them for pharmacy and provider restriction along with behavioral and pain management referrals.
- Identifying members with asthma who have not filled a prescription controller medication and providing this information to providers so that they can contact the members and discuss the benefits of controller medications and address any member concerns.
- Utilizing our proprietary CORE™ application to proactively alert us about the inappropriate use of ED services
- Analyzing the factors that contribute to increased ED usage, including Geographic Service Area, provider, age, diagnosis, utilization history, pharmacy claims and PCP visits
- Contacting members seeking care with non-participating EDs to discuss available in-network facilities

Intensive Care Management program

Aetna Better Health maintains an Intensive Care Management (ICM) program to identify high risk members who may access ED services and connect them with the right service at the right time. ICM is a means to provide continuity of care through a holistic and culturally competent approach. Aetna Better Health's ICM program matches members with the resources they need to establish a relationship with a PCP as their medical home, improve their health status and to sustain those improvements over time.

Through ICM, Aetna Better Health addresses the needs of members who have multiple co-morbid, complex medical conditions or challenging social situations that make it difficult for members to navigate the health care system. We then address the needs of these individuals through offering a Health Home as a PCP selection option to improve member care management. We use evidence-based practices to identify high risk members, and offer them intensive care management services built upon a collaborative relationship with a single clinical case manager, their caregivers and their primary provider. This relationship continues throughout the care management engagement.

We identify members for our ICM Program through several approaches and resources. Members included in our ICM Program, as described above, generally include women with high risk pregnancies and members with multiple chronic conditions (e.g., TBI, development delay, congenital anomalies, liver disease, epilepsy, cancer, mental illness and other chronic conditions). Aetna Better Health uses several methods to identify members who access services through the ED and would benefit from intensive care management services, including:

- Members with:
  - Inpatient admissions including the following: 1) more than three unplanned admissions in six months; 2) any admissions related to ambulatory care sensitive conditions, 3) currently receiving services in an inpatient facility and is at high risk of readmission, and 4) complex discharge planning needs and follow-up services
  - ED utilization greater than three visits in six months
  - Inadequate medical home [e.g., lack of coordination, member does have documented visits with PCP or OB (if pregnant)]
  - Complex social factors (e.g., unsafe living conditions)

  - Complex clinical co-morbidity (e.g., multiple Public Health and Behavioral Health diagnoses)
  - Multiple specialists (e.g., greater than three types of specialists whose services require coordination)
  - Evidence of five or more medications from different therapeutic classes
  - Life expectancy of less than 5 months, per their PCP
- Information provided on enrollment files
- Information received from internal and external sources such as State or community sponsored programs, welcome calls, and prevention and wellness outreach activities
- Referrals from our PCP network, service and specialty providers, schools, community-based organizations, members and their families
- Health Risk Questionnaire (HRQ), which is conducted within 90 days of enrollment, provides self-reported information resulting in member identification
- Surveillance methods such as complaints and appeals, pharmacy management, quality management, prior authorization and concurrent review activities are also used for case identification

Once a member is determined to need intensive care management services, a highly skilled case manager conducts an interview to identify the root causes driving poor health and the critical barriers to improvement. These might be related to their physical health or behavioral health conditions directly, to psychosocial issues that affect the member's ability to participate effectively in their own care, or to barriers created by the health care system itself. The member and case manager then collaborate to identify the highest priority issues, goals important to the member, and activities to reach those goals. Engaging and motivating members to make critical changes in persistent patterns of behavior and to assume greater responsibility for their health as care management progresses are essential skills for the case managers.

Aetna Better Health's ICM Program results in improved clinical outcomes for our members, who as a result require fewer and less intensive health care services over time. As members move toward autonomy, their intensity of services begins to diminish. Through this process, our case managers connect members to their medical home, teach them how to access the right services at the right time, thus improving their ability to manage their health symptoms in appropriate settings, thereby improving health outcomes and reducing system costs.

Disease Management Program

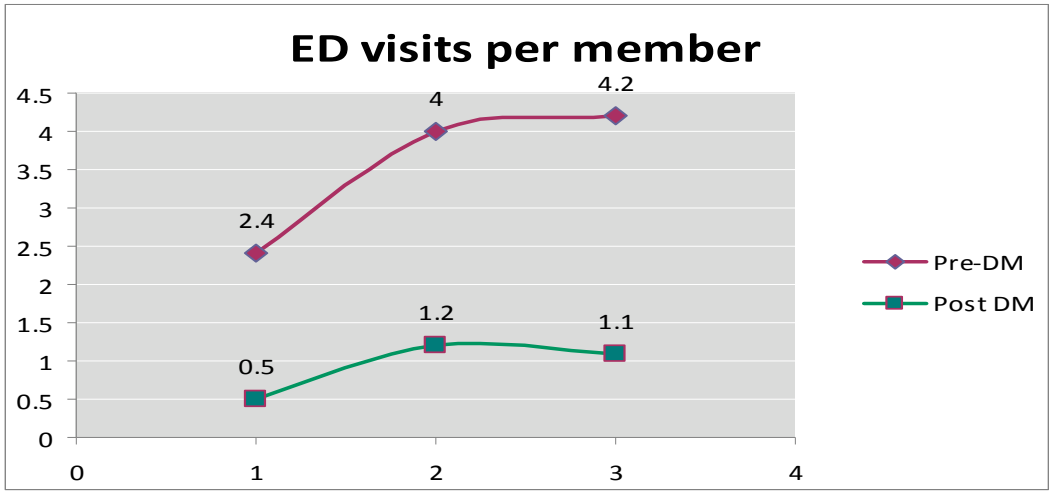
Aetna Better Health further targets reduction in ED use through our disease management program provided by Schaller Anderson, LLC (Schaller) as part of a management agreement. Schaller has operated an NCQA certified disease management program for targeted chronic diseases (e.g., congestive heart failure, chronic obstructive pulmonary disease, depression, asthma, and diabetes) since 2006. The interventions for these targeted chronic diseases are based on Evidence-Based Clinical Practice Guidelines. It is our experience that greater emphasis on disease prevention and management of chronic conditions often results in improved health outcomes and quality of care, and a reduction in ED utilization.

In our experience Schaller's Disease Management (DM) program emphasizes self-management support and member and member family/caregiver education improving healthcare outcomes for members by facilitating their relationship with a medical home. tour disease management program goals include to 1) increase the number of members using their medications correctly, 2) reduce morbidity and mortality of the disease; 3) decrease the incidence of ED visits and hospital admissions/length of stay; 4) engage the member and the member's family/caregiver in maintaining a member's wellness in the most integrated setting 5) teach self-management skills, and 6) support both the member and the PCP/provider in establishing a consistent relationship that improves adherence to the members' care plan.

Schaller's DM program also focuses on providers, and includes specific program elements for 1) education of PCPs/providers regarding Evidence-Based Clinical Practice Guidelines and that adherence to these guidelines improves members' health outcomes; 2) the PCP/providers to be involved in the implementation and evaluation of the program, including through our QM/UM Committee; 3) monitoring PCPs/providers compliance with the Evidence-Based Clinical Practice Guidelines; 4) methods to improve PCPs/providers compliance with Evidence-Based Clinical Practice Guidelines, including but not limited to, corrective action plans or individualized training with QM RN personnel, CMO, or designee.

Our voluntary comprehensive DM program includes the following: 1) incorporating the member's bio-psycho-social needs in the member's care plan; 2) collaborating with the member and the member's family/caregiver to identify the member's goals for management of their disease/condition, quality of life expectations, and interventions founded on evidence-based guidelines to support those goals; 3) teaming with the member, and member's family/caregiver, assigned CM, and key providers (e.g., PCP, BH provider) to identify the member's needs and strengths implement successful interventions founded on evidence-based clinical guidelines and eliminate any barriers to care; 4) developing a care plan to address the member's critical physical, behavioral and social needs to promote resiliency, recovery and optimal self-management with specific member outcomes; 5) educating members about their chronic disease and effective tools for self-management and evaluating the effectiveness of this member education as it relates to the members' self-management of their disease; 6) promoting access to a continuum of services, including community services, based on the intensity and complexity of the member's needs; 7) monitoring member outcomes to assess the program's effectiveness; and 8) keeping the member's PCP informed about the member's enrollment in the Disease Management program and the disease management activities and outcomes.

Mercy Care Plan (MCP), our Aetna Better Health affiliated plan in Arizona, conducted an outcome analysis of Schaller's DM program for PCP visits and ED visits. They compared pre- and post-enrollment for members who were enrolled in our disease management program between 2007 and 2009. As demonstrated in the graph below, MCP found that ED visits, along with per member per month expenditures, were consistently lower for all three measurement years after members enrolled in our disease management program.


ED visits per member
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
0
1
2
3
4
2.4
4
4.2
0.5
1.2
1.1
Pre-DM
Post DM

AREA OF INTEREST 5: EPSDT

Aetna Better Health has an established history of providing ready access to preventive care and services, especially for members under 21. It is our experience that these services can prevent significant health problems and positively affect early social and academic achievement. To this end, we collaborate closely with caregivers, PCPs, community organizations, schools, school districts and other stakeholders to promote an awareness of the importance and availability of well child services and screenings.

Education and Outreach

Aetna Better Health takes several approaches and strategies in an effort to reach and educate our members and their caregivers about the importance and value of preventive services, including EPSDT services. Our approaches and strategies include, but are not limited to, the following:

- New Member Welcome Packets and Welcome Calls which provide information on our services and offers members assistance in accessing EPSDT related services
- Member Handbooks, newsletters and on-hold messages
- Member outreach and education (including mailings, reminder cards for appointments due and missed appointments, and telephone calls)
- Researching returned member mailings in an effort to identify accurate contact information
- Contacting PCPs for assistance in locating members
- Coordinating with state and community organizations, including prenatal clinics and other prenatal care providers, to educate pregnant women and encourage EPSDT visits for infants
- Member incentive and rewards programs
- Including EPSDT standards in provider contracts
- Provider Manuals and newsletters
- Provider outreach and education, including on-site training at provider offices
- Provider Preventive Care Toolkit/CD, with preventive care information, resources and forms
- Eligibility look-up reminders (i.e., when providers check for member eligibility status, they are reminded of any EPSDT encounters or screens due for members)
- Provider patient rosters of children due for a well child appointment
- Provider letters containing information about HEDIS measures, screening, documentation and billing requirements
- Health Plan Web sites
- Community outreach initiatives, including, but not limited to:
  - Back-to-school fairs
  - Local health fairs
  - Swim parties
  - On-site visits to schools
  - Collaboration with community-based organizations

Aetna Better Health uses alternative means of communication for our members whose learning styles are better served through visual or oral presentation approaches. We also offer our preventive educational materials and Member Handbook in alternative languages to meet the needs of our members who are more comfortable with materials in another language. To further address the needs of our members, we provide our personnel with annual cultural competency training and work with our providers to better understand differing cultural beliefs involving health and health care delivery.

Our commitment to an effective EPSDT strategy is based on the principle that early detection is key to reducing costs and improving the health status of infants, children and adolescents. To this end, we never require prior authorization for preventive care services, which include, but are not limited to, the following:

- A comprehensive physical and behavioral health and developmental history, including nutritional status
- A comprehensive unclothed or partially draped physical exam
- Appropriate immunizations
- Laboratory tests
- Vision and hearing screenings
- Dental screens and fluoride treatments for members under 21 years on a once per six-months basis
- Blood lead screening and testing
- Health education, including anticipatory guidance
- Preventive care services for newborns, including inpatient physician visits and routine inpatient and outpatient screenings

We have more than 10 years of experience in developing and implementing programs that emphasize prevention and wellness and the importance of:

- A health care home
- Continuity of care
- Coordination of care
- Identification and utilization of appropriate community resources

Aetna Better Health understands that high quality care includes the establishment of a medical home with a PCP. However, in areas where access issues impede preventive care, we seek partnerships with a broad array of additional supports, including schools, FQHCs and RHCs, Head Start, WIC, day care centers, churches and other appropriate entities to enhance our members' access to preventive services. Consistent with our emphasis on a health care home, we tie reimbursement of these alternative providers to sharing documentation of the visit and any diagnostic outcomes with our health plans and the member's PCP.

Immunizations

Aetna Better Health regularly shares information with members and providers about the importance of immunizations in newsletters, bulletins, flyers and during other communications

opportunities – for instance, when a member contacts us for information or when a provider checks eligibility. We are proud of our outreach efforts and the positive results that are reflected in our HEDIS measurements for well child visits and immunizations.

Aetna Better Health has developed a variety of strategies to track childhood immunizations and comply with state's reporting requirements, including, but not limited to, the following:

- VFC Enrollment: Aetna Better Health encourages all appropriate network providers, including OB/GYNs, to enroll in the Vaccine for Children (VFC) program to obtain free vaccines for Medicaid-eligible children and adolescents under the age of 19. Providers submit claims to our health plans to receive reimbursement for administering vaccines to our members.
- Coordination with the State's Immunization Registry Program: Aetna Better Health works in partnership with Immunization Registry personnel to facilitate a seamless exchange of information. Our health plans utilize information received from the registry as a component in developing follow-up strategies for contacting the caregivers of children who are not current with required immunizations.

Dental Care

In addition to its efforts to improve access to well-child EPSDT services, Aetna Better Health has implemented multiple strategies to increase EPSDT-eligible members' utilization of oral health services. As part of our strategy to increase member's use of dental services the member is able to seek care and make an appointment from a participating provider without referral from or coordination by their PCP. The goals of our strategies are to make sure that EPSDT-eligible members receive: 1) required health screenings in compliance with the EPSDT Periodicity Schedule and Dental Periodicity Schedule; and 2) medically necessary dental services including emergency dental services, dental screening and preventive services in accordance with the periodicity schedule, and therapeutic dental services and dentures.

Member Strategies

Generally, member strategies focus on both educational and outreach activities. Examples of recent strategies that we have implemented in other states include:

- General Oral Health Educational Information. Our member handbook contains general information about coverage of dental services and how to schedule them; our bi-annual member newsletter contain articles regarding oral health care (e.g., caring for a child's new teeth, dental problems associated with thumb sucking). These materials, which are written in English and Spanish, are mailed to all our members and are also made available on our website. Additionally, our member services and outreach personnel assist in educating the caller about oral health care and other EPSDT services.
- EPSDT and Dental Reminders. We send mailings to EPSDT-eligible households at various points in time that include:
  - ESPDT-age specific fold-out cards, reminding member households with a child aged one month through 20 years to schedule a well-child check-up. The card lists dental screening as a needed component of the visit and uses the "tips for parents" section on the cards for parents of nine months and two years old to discuss good oral health care for the child.

  - Dental reminder postcards.
  - Follow-up reminder letters
  - A dental education mailer sent to the parents of 12 month old children, urging them to begin routine dental care for their child.
  - For members who are to become age 21 in 6-12 months we send reminder notices to have dental work before their 21st birthday.

    Each of these reminders is available in English and Spanish and lists the phone number the parent/guardian should call if they need any assistance obtaining these services (e.g., finding a dentist, scheduling transportation).

- Targeted Outreach to Members with a PCP Dental Referral. Our personnel review all EPSDT forms and identify those members the PCP has specifically referred for dental services. We subsequently mail these members a letter encouraging the parent/guardian to follow-through on the PCP's recommendations to see a dentist and enclose a copy of an educational leaflet (from the National Institutes of Health) on the importance of good oral health care.

In addition to the strategies described above, Aetna Better Health has focused on making the dental network readily accessible to our members including confirming the number and distribution of dentists meets each GSA's standards and working to see that dentists have experience and training serving individuals with special needs, including serving persons with developmental or cognitive disabilities.

Provider Strategies

Given the important role PCPs can play in educating their patients about good oral health care and encouraging them to seek needed dental care, Aetna Better Health has implemented a number of dental-related strategies targeted to our provider network. Our provider guidance and training includes that the PCP may refer an EPSDT-eligible member for a dental assessment as necessary to treat a condition observed during an EPSDT screen.

- General Education Materials. We use our provider manual and provider website bulletins, both of which are available on our website, as a means to educate our providers about dental coverage for EPSDT children and the PCP's responsibility related to oral health screening and dental referral. A copy of the Dental Periodicity Schedule is included in the manual and on our website.
- Provider Meetings and Site Visits. Our provider relations representatives educate all new providers about EPSDT (including dental screenings and referrals) during initial office visits and include it as an agenda item for our provider office meetings.
- Provider EPSDT Forms. Information provided on the EPSDT form is entered into a database and used for both member and provider outreach.

Methods to Monitor and Increase EPSDT Screening Standards

Outreach and education are critical first steps toward increasing screenings and participation, but it is equally important to monitor progress toward targeted objectives and, if necessary, to develop and implement corrective actions. Aetna Better Health identifies all eligible children, including foster care children, children with developmental disabilities, behavioral health

conditions and other special health care needs, and collects and tracks data to monitor the levels of screening and participation. We incorporate the American Academy of Pediatrics screening benchmarks into the monitoring process and share this information with members, providers, vendors, the State and other appropriate entities.

Aetna Better Health requires providers who deliver well child services to track these services and:

- Document each assessment on the appropriate tracking form and confirm that the record is complete and readable
- Comply with the health plan's periodic review of standards, including chart reviews
- Comply with Minimum Medical Record Standards for Quality Management and EPSDT Guidelines and any other requirements
- Report all encounters on the claims submission form by recording the CPT preventive codes

Aetna Better Health conducts regularly scheduled medical record reviews to see that PCPs' medical records document all screenings and services provided to members and to verify compliance with established regulatory standards. During this review, we verify compliance with EPSDT required screenings in such areas as:

- Appropriate immunizations according to age
- Blood lead testing
- Hearing/vision screening
- Developmental assessment
- Growth screening
- Dental screening/referral
- Anticipatory guidance

If provider records have missing information, Aetna Better Health educates providers on EPSDT requirements. Continual failure on the part of the provider to adequately maintain medical records can result in the provider developing a corrective action plan; ongoing and consistent follow-up with the provider to track improvement; sanctioning the provider by capping enrollment or taking other actions; including termination of the provider's contract.

Barriers to Care

Understanding barriers to access is essential to providing that members receive appropriate services, including regular preventive services. Aetna Better Health trains our member services, care management, grievance and appeals, provider services, quality management, and utilization management (prior authorization, concurrent review, retrospective review) personnel to identify potential obstacles to care during member communications opportunities and to work with caregivers, PCPs and other relevant entities to address them. We find that, although most caregivers understand the importance of preventive care, many confront seemingly insurmountable barriers to readily comply with preventive care guidelines. Examples of barriers to preventive care that we have encountered include:

- Cultural or linguistic issues

- Health literacy issues
- Lack of perceived need if children are not sick
- Lack of understanding of the benefits of preventive services
- Competing health-related issues or other family/work priorities
- Transportation
- Scheduling or other access issues
- Child care
- Adolescent resistance to obtaining "pediatric" care and willingness to participate
- Coordinating care for services delivered by "carved out" vendors

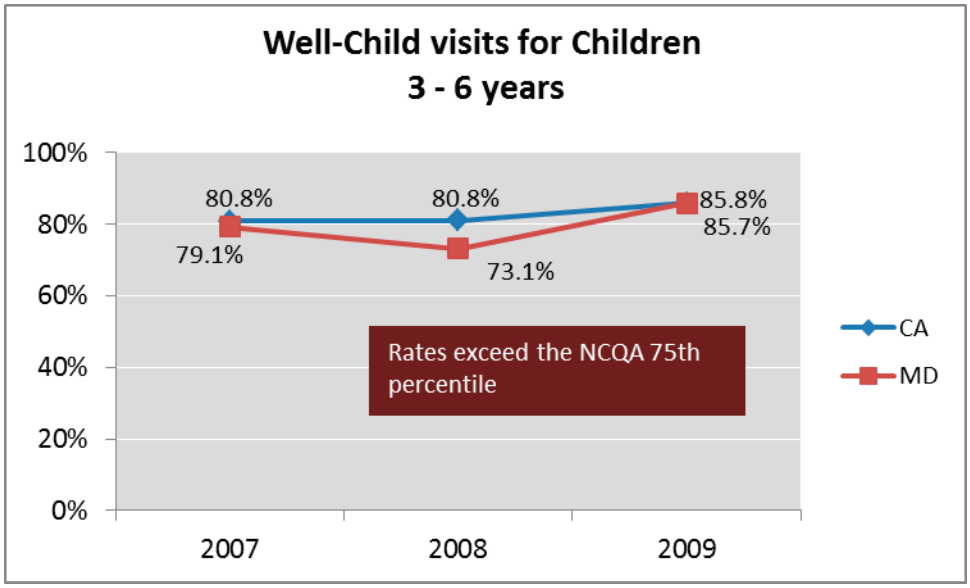
We routinely link members with services designed to enhance access to preventive services, including:

- Facilitating interpreter services
- Locating a provider who speaks a particular language
- Arranging transportation to medical appointments
- Connecting members with other needed community-based support services

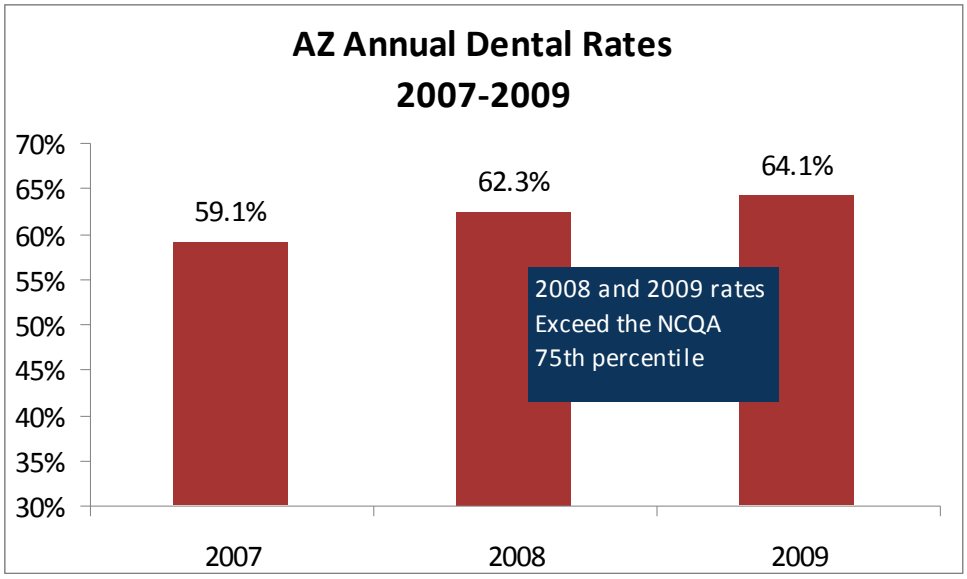
Integration into Case Management Programs

Children may also be referred and integrated into our Case Management Program for further assistance in accessing health care services to meet their needs. Aetna Better Health's case managers are responsible for coordinating and tracking EPSDT services, including services for children with special health care needs. Case managers complete assessments for members less than 21 years of age to identify needed EPSDT visits and incorporate these services into the member's care plan. Our case managers use a variety of care management tools (e.g., CORE™, our proprietary predictive modeling application) and assessments to identify members in need of coordination of care and schedule targeted outreach calls. They enter information gathered from these discussions into our web-based care management business application system (Dynamo™), to enable Care Managers to review a member's encounter history, schedule needed appointments and plan follow up activities.

As a result of our coordinated activities, our annual HEDIS rates for dental visits and well care visits compare favorably to national benchmarks, in many cases exceeding the national 75th percentile rate. Our Maryland, and California health plan have demonstrated statistically significant improvement in and Well Child Visits (3 – 6 Years), with 2009 rates for Maryland Medicaid and the California CHIP programs exceeding the NCQA 90th percentile rate benchmark.



As shown in the graph below, our initiatives to increase EPSDT members' access to dental care has resulted in our Arizona plan far exceeding the national benchmark for annual dental visits for children aged 2 – 21 years old.



AREA OF INTEREST 6: CHILDREN WITH SPECIAL HEALTHCARE NEEDS

Aetna Better Health recognizes the challenges that families of children with special health care needs (CSHCN) confront when navigating the health care system. These children often have complex physical and/or behavioral health care needs and multiple social issues requiring professional assistance from an array of specialists, sub-specialists and community-based organizations. Our service delivery system for CSHCN promotes the early identification of physical, behavioral and developmental problems, preventive health services and outreach and education in accordance with state Medicaid program requirements. Our goal has been, and remains, to improve the quality and cost effectiveness of Medicaid managed care, particularly for vulnerable and high need populations.

A key component of our programs is the coordination of care with other public entities, such as:

- Title V maternal and child health programs
- Local public health agencies
- Substance abuse and mental health agencies
- Education system including schools and school-based programs
- Judicial system including juvenile court programs
- Providers of essential community services

Importantly, Aetna Better Health recognizes the critical importance of maintaining the continuity of medically necessary physical, occupational and speech therapy for CSHCN. To this end, we coordinate service delivery with the public school systems and the therapy providers through the Individual Family Service Plan (IFSP) and Individual Education Plan (IEP) processes. This entails assembling all personnel involved in the member's care to review medical necessity and prioritize a plan of care, thereby improving the chance that the child and family will receive seamless care coordination services across all relevant agencies.

The system of care for children and young adults with special health care needs involves:

- An expeditious and coordinated process for identification and referral of children and young adults with special health care needs for assessment and development of a plan of treatment
- Having specialists serving as the child's PCP, if acceptable to the child's caregivers
- Active involvement of the child's PCP and specialists in the treatment planning process
- Specialized prior authorization procedures
- Direct access to a specialist(s), as appropriate
- Ongoing assessment to identify any special conditions that require a course of treatment or regular care monitoring

Aetna Better Health's services for children with special health care needs are available to all enrolled Title XIX members from birth to age 21.

Experience

Aetna Better Health, together with its affiliates, has actively managed children with Special Health Care Needs (SHCN) in our Medicaid programs for more than 25 years. Children with SHCN in our care management program, suffer from high risk conditions such as prematurity; ADHD; asthma; and children with serious or multiple chronic conditions (e.g. cystic fibrosis and epilepsy). We have developed a core competency in managing integrated health models for Medicaid and SCHIP, including children with special health care needs.

For children with special health care needs, we have an intensive case management program that involves the establishment of a close working relationship between the RN Case Manager, the member, the member's family/caregivers, specialists and PCP/PCMH. Using disease-specific evidence-based guidelines and protocols, our RN Care Managers serve as the members' advocates, integrating the resources necessary to successfully meet their complex health care needs. Our Case Managers also work with local health departments in collaborative meetings with school nurses to share data, information and prevention strategies. Our Case Managers also assist members in identifying a PCP to serve as the PCMH. For children with special health care needs, a specialist may serve as their PCP, allowing them access to specialty care services while receiving services through the medical home model.

Identification of Children with Special Health Care Needs

In addition to the identification of CSHCN through the Title V program, Aetna Better Health employs a variety of additional strategies:

- Predictive Modeling – Aetna Better Health uses a proprietary risk assessment application called CORE™, which is a proven technology for identifying members who currently have or are at risk of developing complex and/or chronic health care needs. CORE™ accomplishes this task through an internal diagnostic grouping process that evaluates over 15,000 ICD-9 codes and identifies specific chronic and acute conditions having long recovery timeframes (such as spinal cord injuries) or commonly recurrent conditions (such as respiratory infections). The grouping logic ranks members according to the type of claim, the frequency of the diagnosis, the provider specialty and other relevant data. The goal is to accurately identify a primary condition for each member.
- Member Outreach – Aetna Better Health sends materials to all enrolled members (in member newsletters, the Member Handbook, EPSDT reminders, disease management newsletters) that provide detailed information about services available to CSHCN. In addition, our Welcome Calls are also used to provide information regarding programs for CSHCN if the caregiver indicates their child meets these criteria and to provide assistance in accessing needed services. We refer these members (or caregiver) to our Case Management Department for follow-up. Caregivers are encouraged to call our Member Services Department if they have a child in need of such services or suspect they may have a need.
- Network Providers – Aetna Better Health believes it is imperative for our network providers to be active partners in identifying and managing the care of CSHCN. We educate our providers about CSHCN through newsletters and special educational forums, including information about the referral process and the responsibility of the provider in caring for these members.

When we identify a CSHCN, an Aetna Better Health case manager contacts the child's caregiver to determine if the child has proper access to needed services and to assist in making any necessary referrals. We make a focused effort to include specialists with particular medical expertise and interest in caring for CSHCN in our provider network. In addition, we provide covered, out-of-network specialty services, as appropriate, for the member's condition and identified needs. This includes coordinating transportation (if necessary) and supporting the member and the member's caregiver during the process.

Goals of Case Management

Aetna Better Health's case management personnel assess each member's level of risk, barriers to care and their unique circumstances. We then develop a collaborative care plan tailored to promote improved health outcomes. We design our case management program to achieve the following goals:

- To stabilize and prevent further deterioration of members' medical conditions through the integration, coordination and provision of appropriate services to meet members' needs in a holistic manner
- To promote consistency in the delivery of physical and behavioral health care services
- To integrate service delivery among state agencies, school districts, community organizations, PCPs and specialists
- To target members who continue to frequently use Emergency Department services and develop a specific plan of care to reduce or eliminate this utilization
- To encourage the use of a PCP/PCMH and preventive care services (e.g., screenings, immunizations, etc.)
- To monitor and evaluate individualized care plans for their effectiveness in achieving agreed upon goals and make revisions as needed

Improvement Activities and Initiatives

Aetna Better Health has successfully implemented an array of initiatives specifically designed to meet the needs of CSHCN, including a data mining and analysis strategy for the early identification of children with special needs. In addition to the proactive identification strategies discussed above, we also use data from the following sources to assist in this objective:

- Health Risk Assessment data
- Provider and community agency referrals
- Outpatient utilization
- Inpatient utilization
- Durable medical equipment requests

By proactively identifying children with special heath care needs, Aetna Better Health has improved access to appropriate services.

To continue to meet the intense and diverse care requirements of children with special health care needs, Aetna Better Health has implemented the following interventions:

- Our CSHCN screener identifies children experiencing one or more current functional limitations or service use needs as a result of an ongoing physical, emotional, behavioral, developmental or other health condition and referring the child for appropriate intensive case management
- Development of an Attention Deficit/Hyperactivity Disorder (ADHD) Toolkit that is distributed to all network PCP offices and is made available on our health plan's websites

Outcomes

Through our intensive care management programs, children with special health care needs receive enhanced care coordination services, improved access to specialty care services, and access to a patient-centered medical home.

AREA OF INTEREST 7: ASTHMA

Aetna Better Health recognizes that Asthma is one of the most prevalent chronic diseases, affecting children and adults alike. It can significantly affect members' ability to function in their daily activities and can lead to missed school and workdays as well as increased utilization at urgent care facilities, Emergency Departments with subsequent inpatient hospitalizations.

According to a report by the National Institute of Environmental Health Sciences (2006), 30.8 million people in the United States have Asthma, including over six million children under the age of 18. This is approximately 10 percent of all adults and 12 percent of children. The numbers are very similar in Louisiana. According to the 2008 Louisiana Burden of Asthma Report, 11.7% of adults in Louisiana have been diagnosed with asthma and in 2008, the percentage of residents between the ages of 18-24, with current asthma, doubled from 6.3% to 13.3%. Additionally, 44% of children with Asthma in the Louisiana Medicaid program had emergency room visits last year.

According to experts at the American College of Allergy, Asthma and Immunology (ACAAI), barriers to managing Asthma include access to appropriate care, patient adherence, distrust of the medical profession, delayed Asthma diagnosis, culture, lifestyle choices and genetic discrepancies.

In our experience, factors limiting adherence to a patient's Asthma management plan are low health literacy; financial and economic barriers; environmental factors at home; and customs, cultural or religious beliefs that impact the use of health care services. Additional factors include:

- Resistance to taking multiple medication or the belief that the medication helpful
- Concerns about the potential side effects of the medication
- Inadequate accessibility to rescue medication
- Multiple care givers to treat Asthma
- Difficulty using the medicine or children who refuse medications
- Inconsistent or difficulty scheduling appointments with providers

Experience

Aetna Better Health uses Schaller Anderson's NCQA-certified disease management program for Asthma, a comprehensive disease management program that has improved member health outcomes, reduce costs, and reduce emergency room visits. This program promotes necessary preventive health services, treatment, outreach and education for asthmatic members. The program is available to both adults and children and includes patient education and outreach with physician interaction and support. Asthmatic members are identified using our proprietary predictive modeling tool or can be referred to the program by their PCP, health plan personnel (i.e., prior authorization, concurrent review), or may refer themselves. Once identified, members work with our personnel to answer a series of question to determine their current health care knowledge related to Asthma as well as their adherence to standard treatment guidelines, use of emergency services and any other health care condition they may have.

Goals

The goal of our Asthma Disease Management Program is to improve the member's functional status and enhance their ability to self-manage their Asthma so that they can minimize the extent to which it interferes with their lives. We target the following improvements in the care of Asthma:

- Reductions in inpatient admissions and avoidable ED utilization
- Improvement in medication adherence
- Improvement in member adherence to Asthma treatment guidelines

Program Components

Our Asthma Program follows the basic principles and component set in all of our disease management programs. These include:

- Interventions and care planning
- Member education
- Targeted member specific educational mailings
- Quarterly education mailings
- Individual member health profiles
- Web site with access to searchable data for additional information and education

We also work with the member's PCP to support a cohesive care plan. Provider involvement includes:

- Notification of member enrollment
- Provider follow up on member appointments and compliance with care plans
- Sharing of individual member health profile
- Web site with access to searchable data for additional information and education

Using our Consolidated Outreach and Risk Evaluation (CORE) tool, we identify those members who are at greatest risk for ED visits due to poor health outcomes associated with their chronic condition. Based on the outcome of this evaluation, we assign members to the appropriate level of Disease Management Services. Members may move between levels of care based on changes in their health status.

Low risk Aetna Better Health members receive:

- An introductory letter from Schaller Anderson's Disease Management Program explaining the program benefits
- Periodic health reviews through the ongoing monitoring of claims (medical and pharmacy) activity and other tools to confirm risk and appropriate program intervention level
- Educational materials through Schaller Anderson's quarterly disease specific disease management newsletter – Pathway to Asthma Care. The newsletter provides articles on living with Asthma
- Access to Schaller Anderson's Disease Management website, for program overview, educational materials and clinical guidelines.

High-risk Aetna Better Health members receive:

- An introductory letter from Schaller Anderson's Disease Management Program explaining the program benefits
- A Welcome Call from disease management personnel, who will answer questions, provides more info about the Asthma Disease Management Program, complete an initial questionnaire and set up a health history call with one of our nurse disease managers.
- An in-depth disease specific questionnaire completed by the nurse disease manager during the next call to gather information on clinical and psychosocial factors and reviews the member's needs and goals.
- Educational materials are sent, as needed, to the member, such as:
  - Asthma Treatment Plan
  - Asthma Warning Signs
  - Peak Flow Meeting Chart
- Quarterly Member Newsletters: Pathway to Asthma Care. These are sent to all program members; the newsletter provides articles on living with Asthma, as well as general health topics.
- Outbound Calls: regularly scheduled based upon the members needs; for education, coaching on self-care management and assistance with issues.

Performance Improvement Activities

In addition to our proactive disease management strategies described above, Aetna Better Health develops performance improvement projects to target improvement activities and improve member health outcomes. For example, our Missouri subsidiary, Missouri Care, implemented an asthma management program that resulted in a 46% reduction in emergency room visits per member per year and a reduction of $146 in costs per member per month.

Missouri Care's (Aetna Better Health affiliate) asthma management program resulted in a 46% reduction in emergency room visits per member per year.

Missouri Care selected interventions for each improvement activity that are the most cost effective and have the highest likelihood of success. Missouri Care, using Asthma-specific interventions, developed and implemented a PIP targeted at members diagnosed with Asthma in an effort to reduce Emergency Department (ED) utilization and promote positive health outcomes.

Since controller drugs used on a daily basis by patients with persistent Asthma have shown to reduce exacerbations requiring emergency care and hospitalization, the purpose of this PIP was to increase the percentage of Missouri Care members who are correctly taking the appropriate medications (i.e., controller medications).

As part of this initiative, Missouri Care partnered with a local physician's group to improve their program for asthma management for both our adult and child members. Under the program, Missouri Care provided PCPs with 1) formal training; 2) asthma guidelines and sample asthma action plans to use with members; and 3) quarterly roster mailings identifying their members with persistent asthma but without a fill for controller medications. Missouri Care mailed

quarterly member lists to primary care providers of members who, based on claims data, had persistent asthma but who have not had a fill for a controller medication in the previous 12 months. The list was sent to the members' primary care provider along with a cover letter educating the provider on current asthma guidelines, encouraging the use of asthma action plans and referring them to the National Asthma Education and Prevention Program (NAEPP) guidelines. Copies of the guidelines were sent with the first mailing and a sample asthma action plan was sent with every mailing. A concurrent review nurse attempted to contact any member hospitalized with an asthma diagnosis following their discharge to assure that the member fills and properly takes their medications. Members in case management with a diagnosis of asthma were educated on proper medication adherence. Additionally, the Plan's Quality Management Department sent letters to members who met the HEDIS criteria for persistent asthma and have not had a controller fill to encourage these members to schedule appointments with their providers. Missouri Care's Medical Director also phoned providers when members were identified as discharged from the hospital for asthma exacerbation without a controller medication.

Outcomes

This initiative resulted in cost-savings for the Plan and Medicaid program due to a reduction in avoidable inpatient admissions. Examples of outcomes from this initiative are presented in the table below.

Aetna Better Health (2008-2010)	Asthma	
	Pre DM	Post DM
ED visits per member/year	3.7	1.7
PCP visits per member/year	6.7	6.6
Inpatient admits per member/year	11	0
Cost PMPM	$259	$113

AREA OF INTEREST 8: DIABETES

Aetna Better Health realizes that complications from diabetes contribute to significant co-morbid health conditions, rising health care costs, and poor health outcomes for members. Maintaining appropriate blood levels by receiving recommended blood tests mitigates those risks; however, many members with diabetes fail to access these services, as evidenced by Louisiana's report that only 66% of their Medicaid members with Diabetes received HbA1c tests in 2008. To address these issues, our disease management programs have embraced innovative interventions to increase member education and improve health outcomes for members with Diabetes.

Aetna Better Health has a robust care management program that includes the use of Schaller Anderson's disease management programs that are certified in program design by NCQA for Diabetes. The disease management program for Diabetes encompass the management of depression and obesity, since these frequently present as co-occurring disorders for persons with this chronic condition. Our Diabetes disease management program also recognizes: 1) health literacy, 2) ethnic and cultural disparities in care, and 3) linguistic issues that may impede the treatment and management of a member's medical conditions. Our program aims to reduce the frequency and severity of exacerbations caused by Diabetes.

Schaller Anderson developed these disease management programs based on disease prevalence, including co-morbid conditions, and our ability to intervene effectively to improve patient outcomes. Our approach combines member education, member self-management and evidence-based practice guidelines with established metrics to monitor provider compliance with those guidelines.

Schaller Anderson's disease management program promotes productive interactions between active and engaged members (as well as the member's family/caregiver) and a prepared team of health professionals with the goal of delivering effective, timely, member-centered, efficient and equitable support. To achieve the aim of motivating and engaging members and preparing our disease management personnel to support their needs, the program places emphasis on providing self-management support, designing an effective delivery system, and enhancing decision support and clinical information systems.

Outreach and Education

Aetna Better Health educates members and providers about our Diabetes disease management program through a variety of strategies, including, but not limited to:

- Member Welcome Calls
- Member Handbook and Provider Manual
- Member newsletters, bulletins and informational flyers
- Provider newsletters, bulletins and informational flyers
- Targeted member and provider mailings
- Outreach calls
- Aetna Better Health's Web portal

Aetna Better Health also includes information about our Disease Management Program for members with Diabetes in the New Member Welcome Packet and during new member welcome calls. Members with Diabetes identified as low risk and targeted for enrollment are outreached through a mailing that outlines the Diabetes DM program and its benefits. Our Diabetes disease management personnel provide telephonic outreach services to members identified with higher risk factors.

Engaging members in a Disease Management Program can prove challenging. For this reason we have integrated disease management into our overall care management processes. The trust that typically develops in the member/disease manager relationship can play a pivotal role in enhancing disease management (DM) identification, participation and compliance. We train our disease managers in motivational interviewing techniques to empathize with the member while supporting the member's self-efficacy and creating optimism.

Our objective is to enroll members in DM as early in the development of the disease state as possible. To this end, we utilize an "opt out" enrollment methodology in which we automatically enroll identified members in the program unless they specifically request to be excluded.

Member Identification and Referral

Aetna Better Health utilizes CORE™, our proprietary risk modeling application, to identify members with Diabetes who need Disease Management Services. To accomplish this, CORE™ sorts and analyzes the following information:

- Claims history
- Pharmacy records
- Clinical and available laboratory data
- Demographic information
- Variances from evidence-based guidelines
- Diagnostic categories

CORE uses an empirically sound database to identify members based on the following indicators:

- Patterns of care for Diabetes (i.e., over-and-under utilization of services)
- Physical, behavioral health or substance abuse conditions
- Hospitalizations
- Re-admissions within 30 days of discharge
- Conflicting or potentially unsafe drug therapies
- Co-morbidities (behavioral or physical) which may compound a primary condition and increase future health care risk

CORE funnels this information into an online member profile. The member profile enables disease management personnel to access a concise, rolling 12-month view of the member's health care utilization activity, including all hospitalizations, urgent care and ED visits as well as pharmaceutical records. CORE also acts as a tool to support the facilitation of care coordination

between all medical management functions (concurrent review, prior authorization, and case management).

In addition, we employ a variety of other methods and tools to identify members with Diabetes who could potentially benefit from disease management, including:

- Member, family or caregiver referrals
- Provider referrals
- Referrals from community-based organizations and programs
- Referrals from Aetna Better Health's Case Managers, Hospital Concurrent Review Nurses, Medical Directors or Discharge Planners

Program Components

Schaller Anderson's Diabetes Disease Management Program provides members with the following:

- Assessments and care planning
- Member education including targeted member specific educational mailings, quarterly education mailings, individual member health profile, and a Web site with access to searchable data for additional information and education (i.e., Medline Plus and Krames on Demand™)
- Provider involvement, including notification of member enrollment, collaboration on goals and care plan by individual member, provider follow up on member appointments and compliance with care plans, sharing of individual member health profile, and Web site with access to searchable data for additional information and education (i.e., Medline Plus)

Interventions

Regardless of risk level, members enrolled in our Diabetes disease management program receive:

- An introductory letter from the Disease Management Program explaining the program benefits
- Educational materials to improve a members health knowledge through quarterly disease-specific newsletters that provide articles on living with disease conditions
- Access to the Aetna Better Health Web site for program overview, educational materials and clinical guidelines

Low risk members receive periodic health reviews through ongoing monitoring of claims (physical health, behavioral health and pharmacy) activity and other tools to confirm risk and appropriate program intervention level (completed monthly).

High-risk members also receive:

- A Welcome Call from a Disease Management Care Coordinator, who answers questions, provides more information about the Disease Management Program, completes a short questionnaire and schedules a health history call with one of our Disease Management Nurses

- Our disease management nurses intervene with members by collecting in-depth health history including clinical information using a biopsychosocial foundation
- Tailored educational materials designed specifically for the member's identified disease condition
- Outbound calls are scheduled based upon the member's needs to provide member education, coaching and goal setting on self-care management and assistance in resolving issues and/or barriers in managing their condition
- Provider notification of member participation, member identified goals and health profiles to inform the provider on the member's utilization summary

Focused Improvement

Aetna Better Health also develops performance improvement projects to target improvement activities and improve member health outcomes. For example, our Aetna Better Health affiliated plan, Delaware Physicians Care, Inc. (DPCI), implemented an innovative communication strategy to increase compliance with HbA1c testing for members with diabetes. DPCI designed the program under the assumptions that members have cellular telephones, that cellular phones are often more reliable than land lines and that we could use text messaging to discreetly remind members about the HbA1c test. Through this program, DPCI sent educational messages and routine reminders to members regarding completion of recommended Diabetes testing.

To enhance the service, DPCI also texted a Diabetes related health tip every month. We integrated the text alert system with our laboratory system that documents when a member received the test and generates a congratulatory message for its completion. The goal of the study was to increase the percentage of diabetics receiving at least one screening in a six-month intervention period.

Outcomes

We are pleased to report that, for members who agreed to participate in this program , the percentage receiving HbA1c tests increased from 52.3 percent to 70.5 percent ($p < 0.05$), as measured by HEDIS. DPCI currently plans to expand the use of text messaging to other member groups and is considering new clinical applications for the technology.

AREA OF INTEREST 9: CARDIOVASCULAR DISEASE

In 2008, 31 percent of deaths in Louisiana were attributed to cardiovascular disease, demonstrating that access to appropriate care for members with cardiovascular disease is critical for reducing negative health outcomes. Aetna Better Health's chronic disease management programs have successfully improved access to preventive care for members with cardiovascular disease, improving health outcomes and reducing costs associated with avoidable hospitalizations.

Aetna Better Health uses Schaller Anderson's NCQA-certified disease management program for Congestive Heart Failure (CHF), a comprehensive disease management program that has proven to improve member health outcomes, reduce costs, and reduce emergency room visits. This program promotes necessary preventive health services, treatment, outreach and education for members with CHF. The disease management program for CHF encompasses the management of depression and obesity, since these frequently present as co-occurring disorders for persons with this chronic condition. Our program aims to reduce the frequency and severity of exacerbations caused by one or more chronic conditions. The program is available to both adults and children and includes patient education and outreach with physician interaction and support.

Members with CHF are identified using the Consolidated Outreach and Risk Evaluation (CORE), our proprietary predictive modeling tool or can be referred to the program by their PCP, health plan personnel (i.e., prior authorization, concurrent review), or may refer themselves. Once identified, members work with our personnel to answer a series of question to determine their current health care knowledge related to CHF as well as their adherence to standard treatment guidelines, use of emergency services and any other health care condition they may have.

Goals

The goal of our CHF Disease Management Program is to improve the member's functional status and enhance their ability to self-manage their CHF so that they can minimize the extent to which it interferes with their lives. Our disease management program for CHF targets the following improvements:

- Reductions in inpatient admissions and avoidable ED utilization
- Improvement in member adherence to CHF treatment guidelines

Program Components

Our CHF Program follows the basic principles and component set in all of our disease management programs. These include:

- Interventions and care planning
- Member education
- Targeted member specific educational mailings
- Quarterly education mailings
- Individual member health profiles
- Website with access to searchable data for additional information and education

We also work with the member's PCP to support a cohesive care plan. Provider involvement includes:

- Notification of member enrollment in the disease management program
- Provider follow up on member appointments and compliance with care plans
- Sharing of individual member health profile information
- Access to our website with searchable data for additional information and education

Interventions

Using our CORE tool, we identify those members who are at greatest risk for ED visits due to poor health outcomes associated with their chronic condition. Based on the outcome of this evaluation, we assign members to the appropriate level of Disease Management Services. Members may move between levels of care based on changes in their health status.

Low risk Aetna Better Health members receive:

- An introductory letter from Schaller Anderson's CHF Disease Management Program explaining the program benefits
- Periodic health review through ongoing monitoring of claims (medical and pharmacy) activity and other tools to confirm risk and appropriate program intervention level
- Educational materials through Schaller Anderson's quarterly disease management newsletter
- Access to Schaller Anderson's Disease Management Web site, for program overview, educational materials and clinical guidelines.

High risk Aetna Better Health members also receive:

- A Welcome Call from disease management personnel, who will answer questions, provide more info about the CHF Disease Management Program, complete an initial questionnaire and set up a health history call with one of our nurse disease managers.
- An in-depth disease specific questionnaire completed by the nurse disease manager during the next call to gather information on clinical and psychosocial factors and reviews the member's needs and goals.
- Quarterly Member Newsletters: These are sent to all program members, the newsletter provides articles on living with CHF, as well as general health topics.
- Outbound Calls: regularly scheduled based upon the members needs; for education, coaching on self-care management and assistance with issues.

Focused Improvement

Aetna Better Health and its affiliated health plans routinely evaluate the success of its disease management programs. Through our QAPI program, we determine the need to implement improvement initiatives to promote enhanced health outcomes for our members. For example, an Aetna Better Health Affiliate, Delaware Physicians Care (DPCI), a Managed Care Medicaid Plan, initiated a targeted improvement plan when its analysis of claims data showed that 60% of their inpatient costs for members with cardiovascular disease were caused by 40% of patients with multiple inpatient stays and emergency room encounters.

To improve access to care for members with a history of heart failure, DPCI collaborated with one of the largest health care providers in the mid-Atlantic region to determine if early and

ongoing intervention using tele-health in Medicaid members with CHF would reduce hospitalization and emergency room encounters. A pilot study was implemented to provide in-home tele-monitoring to members with CHF. The plan included identification of members who met the selection criteria for the intervention and standardized telephonic visit modules for patient education.

DPCI's (Aetna Better Health affiliate) Control Your Heart for the Future program saved the Medicaid program $113, 051

The **C**ontrol your **H**eart for the **F**uture cross-functional workgroup participants met weekly, then bi-weekly and finally monthly for ongoing joint decision-making to ensure that the pilot remained on target.

Based on the pilot program framework, interventions included:

- Member letter solidifying the member's agreement to participate in the **C**ontrol your **H**eart for the **F**uture pilot program for 12-13 weeks
- Provider letter informing the PCP and Cardiologist of the **C**ontrol your **H**eart for the **F**uture pilot program, asking for their support given that a member of their panel had agreed to participate.
- PCP and Cardiologist Provider Outreach calls by another Medical Director to introduce the program and solicit their buy-in.
- In-home monitoring with Field Based Case Management
- Obtain land lines for members without phones compatible with the in-home monitoring equipment
- Obtain scales and blood pressure cuffs for members to sustain self-management activities

Outcomes

Pre and post financial information showed significant cost savings and the effectiveness of in-home monitoring with field-based case management coordination. Both the member clinical outcomes and member quality of life outcomes indicate that for this cohort of members, in-home monitoring with field based case management results in members being better able to self-manage their condition and incurring less inpatient hospitalizations and ED visits, resulting in a cost savings of $113,051 for the Medicaid program.

AREA OF INTEREST 10: CASE MANAGEMENT

Aetna Better Health's daily work is to positively affect the health status of our vulnerable population. Our commitment is to improve member health outcomes, enhance their quality of life and reduce racial and ethnic health disparities by providing needed care in the most appropriate setting. Aetna Better Health, together with its affiliates, has more than 25 years of proven performance in serving Medicaid members, with special expertise in the provision of care coordination and Case Management Services.

We recognize that working collaboratively with members and caregivers, providers, community organizations and state agencies improves the quality of health care services for our members. With this in mind, we have implemented a member-centered case management model that both meets the State's case management requirements and holistically integrates prevention, wellness, disease management and specialized programs to appropriately coordinate care across an episode or continuum of care. Our case management program has been successful in:

- Directing members to care in the most appropriate, least restrictive setting allowing us to improve patient care and achieve positive health outcomes
- Reducing unnecessary hospital admissions and readmissions and thereby lower costs
- Assuring access to the full continuum of services that may be needed by members/families with complex issues
- Building partnerships with stakeholders to support our members and their caregivers
- Supporting our primary care providers and the health care home they provide our members
- Enhancing member's self-management of care, creating opportunities to enhance outcomes over the long term

Aetna Better Health's member-centered case management model has four key components for coordinating care, including:

Resource Locator – Identifying and connecting members with the benefits and services that meet their needs, goals and priorities, including caregivers and family members, focused on social, physical, substance abuse and behavioral health

Coordinator of Care – Coordinating services based on needs, goals and member's priorities; communication across the spectrum of health care providers (e.g. physicians, community-based organizations, waiver programs, school-based services); providing the right services at the right time with the right resource; and integrating of the behavioral (including substance abuse), physical, social and educational needs of members

Integrator Role – Developing consolidated individualized care plans that incorporate the members' needs, goals and priorities, with input from the health care home, as well as specialists and community resources as needed

Advocate Role – Serving as the member advocate "To Make It Happen" by removing barriers to care, providing education about conditions, available benefits and services, community resources, and access to care; communicating information between all health care providers, including health care home and physical health specialists, behavioral health providers and

services, community and waiver case managers and caregivers, family members, etc., while serving as a single point of contact.

We deliver our successful case management model by:

- Integrating needs with services, using an integrated model of care delivery
- Focusing on the special needs of the chronically ill
- Hiring and training the right personnel
- Using the best tools
- Identifying the right members
- Delivering what members need
- Continuously evaluating our results

We educate and inform our members about the availability of our Case Management Program via the Member Handbook, new member Welcome Calls and Welcome Packets, mailings and direct communications (e.g., member newsletter). Likewise, we educate our providers about our Case Management Program via the Provider Manual, provider site visits, and mailings and direct communications. Additionally, information about our Case Management Program can be found on our Web site.

An Integrated Case Management Model

Unique among health plans, and supported by our extensive experience, our integrated care management (ICM) model recognizes that our members frequently have behavioral and social issues that complicate their medical care. Aetna Better Health's care management model is based on an integration of all the members' needs. This integrated approach to case management focuses on total member health and well-being using the critical components of behavior change, relationship building and engaging community and social systems that wrap around the member, to enhance member resiliency and self-efficacy. We assess members as they present or are identified, evaluate them as "whole" persons and include all elements that may impact their health status. Our tools and services assist members to decrease the need for unnecessary and invasive care and to increase self-management to improve health and well-being.

Following are our guiding principles of our integrated case management model:

- **Moving from disease focus to member focus**: Evaluating every member for physical, behavioral and social risks to their current and future health
- **Identifying and employing the most effective intensity of evidence-based, plan-covered systems and services**: Facilitating access to a continuum of services based on the intensity and complexity of each member's needs
- **Behavioral engagement for change**: Using a single point of contact to engage each member in a plan that addresses his/her critical physical, behavioral and social needs to promote resiliency, recovery and optimal self-management
- **Teaming with the member and care providers to enhance care outcomes**: Working as an interdisciplinary team that combines core competencies in physical and behavioral health

within a systems framework to manage psychosocial complexity and challenging relationships with members and their families

- **Collaboration with plan sponsors to influence benefit design that supports our model:** Focusing on coordinating and integrating fragmented services into a system of care that addresses each member's individual needs within the context of their family and cultural community

Aetna Better Health assigns an interdisciplinary team in the management of members with complex, co-morbid physical and behavioral health issues. This team may also include departmental managers as well as the Chief Medical Officers. One primary case manager from the team serves as the member's single point of contact. Our fully integrated management information system enables our case managers to analyze pharmacy and physical and behavioral health information to support care planning decisions.

Chronically Ill Members

Aetna Better Health's commitment to member care extends specifically to members who suffer from chronic and complex illnesses. To accomplish improved outcomes for this group, our case management team collaborates across health care disciplines and works in partnership with members/caregivers, PCPs, specialists, government agencies, school districts, advocacy groups and local community-based organizations to address each member's individual requirements.

Aetna Better Health's case managers assist chronically ill members by:

- Addressing cultural, economic or social barriers to care
- Coordinating communication among multiple providers about treatment regimens, diagnostic testing and specialist consultations
- Sharing evidence-based guidelines with providers
- Coordinating continuity of care during the vulnerable transition from one level of care to another (e.g., inpatient to outpatient or inpatient to rehabilitation facility) and discharge planning
- Developing individualized care plans and care plan updates and conducting periodic re-assessments of members
- Communicating with members, caregivers and providers to follow up on any outstanding issues

Using the Best Tools: Case Management Tools

To support our case management activities, Aetna Better Health uses two hallmark tools, CORE™ and our web-based care management business application (Dynamo™) system to identify and manage members.

CORE

Aetna Better Health uses CORE to identify members who would benefit from enrollment in case management programs (i.e., members for whom we can improve clinical and financial outcomes). The application *prospectively* identifies members who are at risk of becoming high cost or who present opportunities for improved health outcomes, consistent with evidence-based clinical guidelines.

Through CORE, our case and disease managers have access to information from critical sources such as medical claims, authorizations, pharmacy and behavioral health data including markers that predict both a member's risk and opportunities for intervention. Using these markers, our case managers have instant access to a ranking system for every member that reflects both the level of risk and potential opportunity for improvement.

CORE supports outcomes reporting and the measurement of Return on Investment (ROI) for care management programs.

Care Management Business Application System

To support our case management and assessment process, we use a web-based care management business application (Dynamo™) to store and retrieve member assessments and care plans and trigger pre-defined actions for care coordination. For example, if a member indicates during an assessment that he/she is not taking medications as prescribed, the system will auto-generate a care plan intervention to educate the member about the importance of his/her medications as well as an outreach to the provider to do the same.

Together, CORE™ and our web-based care management business application (Dynamo™) enable our Case Management personnel to identify members with conditions *prior* to the onset of a significant future medical event. This can include existing members who receive a new diagnosis (e.g., cancer, chronic pain, HIV/AIDS). These tools provide a state-of-the-art foundation for our case management activities, including:

- Gathering the results of member questionnaires that address physical and behavioral health conditions, including complex co-morbidities
- Identifying the predicted risk that the member faces given the member's condition(s) and changes over time
- Developing the member's individualized care plan, which coordinates and integrates physical and behavioral health care activities for both covered services and those available through other sources (e.g., community resources and state agencies)
- Monitoring an up-to-date record of the interaction between case managers and members/caregivers, providers and other supports (e.g., community resources, external case managers)
- Analyzing the member's historical and current service utilization, including physical and behavioral health and pharmacy

Specifically, these applications enable our case managers to perform the following functions:

- Coordination of care, including:
  - Detecting inappropriate patterns of care (e.g., over- or under-utilization of services, including pharmacy)
  - Identifying diagnoses or multiple co-morbidities that place members at risk for serious consequences
  - Providing immediate support to members in need in order to reduce inappropriate care
- Monitoring compliance with treatment protocols, including:
  - Untreated co-morbid conditions (missed opportunities)

  - Gaps in care, such as a failure to fill prescribed medications or get a flu shot based on evidence-based guidelines
  - Use of medications that are less than optimal for chronic conditions (e.g., rescue medication for Asthma when controller medications would be more optimal)
- Provider education, including:
  - Providing evidence-based clinical guidelines
  - The provision of preventive screenings and treatments
  - Distribution of member specific utilization summary profiles
- Tracking and trending quality measures, including:
  - Verification that emergency and inpatient hospital services are appropriately used
  - Post-hospital discharge services are adequate, including medication regimen
  - Reductions in inpatient readmissions
  - Inappropriate use of the Emergency Department (ED)

Case Management Personnel Expertise and Experience

Aetna Better Health recognizes that the success of our case management program depends on the clinical expertise and experience of our case managers, who have the ability to coordinate care and drive efficiency while generating quality outcomes for members and maintaining positive financial results for the health plan. All new personnel hired into our Case Management Departments are not only screened for clinical acumen, but for knowledge and experience in working in an integrated environment with specific expertise managing care for Medicaid populations. All clinicians are licensed and are required to have a certain number of years of clinical experience, in nursing and in behavioral health.

Aetna Better Health's case management personnel are trained in conducting a non-confrontational "motivational interview" that has been proven in psychological studies to enhance member participation and self-motivation. The technique involves a non-confrontational "ask" approach designed to uncover discrepancies or inconsistencies in the member's approach to his or her own disease(s) and to guide the member on how behaviors might be changed to improve longer-term health. By using this technique, case managers can often raise a member's awareness and concern, motivating a change in behavior or set of behaviors related to his/her particular health condition.

In addition to experienced and qualified case management personnel, we also continuously monitor our case management caseloads to see that there is adequate staffing to meet our case management requirements, as well as the needs of our members enrolled in the Case Management Program.

Identifying the Right Members for Case Management

Aetna Better Health's Case Management Program is available to all enrolled members as determined to be medically necessary, including transplants. We identify potential candidates for enrollment in case management through the following processes and strategies:

- Predictive modeling
- Information provided through enrollment counseling

- Information provided from the state health risk questionnaire
- Internal and external referrals, screenings of members, including Welcome Calls, prior authorization, concurrent review and prevention and wellness outreach activities
- Referrals from our network of providers, advocacy groups, schools, community-based organizations, as well as members and their families
- Members admitted to a psychiatric hospital or residential substance abuse treatment program

After identification, Aetna Better Health's case managers complete a general care assessment of these potential candidates for case management. During this initial contact with the member, our case managers inform the members about the nature of Case Management Services, the availability of a complaint process, circumstances under which information will be disclosed to other parties and the rationale for implementing Case Management Services. The results of the assessment are then combined with information from CORE™ to stratify members according to their level of risk.

If we stratify a member as requiring moderate or high intensity interventions, we conduct an even more comprehensive baseline assessment. This process assists case managers in garnering a view of the member's overall health care needs and identifies the medical, social and psychological needs of the member's condition(s). The result is the development of an individualized, integrated and practical care plan that addresses all major facets of the member's life impacting the delivery of care. This is also a continuous process, with re-evaluations occurring throughout the member's enrollment in the specialized case management program.

Delivering What Members Need:

Aetna Better Health's case management program is designed to assist members according to their identified needs. For example, for members with multi co-morbid or co-occurring disorders and social factors that impede positive clinical outcomes, we develop interventions to support the member's access to necessary health and support services in order to return the member to an optimal self-care status. However, for low risk members such as those who have post-hospitalization discharge needs, we design shorter term interventions targeted at optimizing their immediate health care goals, while for members who are pregnant, interventions are aimed at facilitating optimal birth outcomes for both mothers and babies.

Care Planning

Following the identification and assessment process, Aetna Better Health's case managers work collaboratively with the member, the member's caregiver, PCP, specialist providers and other stakeholders, as appropriate, to tailor an individualized care plan including mutually agreed upon short- and long-term goals.

Aetna Better Health's case managers regularly evaluate care plans to assess their effectiveness and to provide feedback to the member, the member's caregivers and his or her health care home. The objective of this process is to determine the level of compliance with the care plan and the degree to which the member is attaining mutually agreed upon goals. Our process incorporates a certain degree of flexibility because member situations and needs often change. The evaluation process also considers the member's stage of readiness to change and covers the spectrum of his/her physical and behavioral health and psychosocial needs.

To accomplish this, our care management team collaborates across all health care disciplines and works in partnership with members, primary care providers, specialists, government agencies, schools and school districts, advocacy groups and community-based organizations to address each member's individual needs and development of a plan of care to education and more members to self-care management.

Improvement Activities and Initiatives

Aetna Better Health has implemented an array of interventions and activities to enhance our case management program. We revised our case management process to more effectively identify, stratify and conduct outreach to members who could potentially benefit from case management for both physical and behavioral health conditions including:

- Implementation of a Case Management Referral Form process following meetings with high-volume provider offices to increase case management referrals
- Using data from CORE to rapidly identify and enroll members with high ED usage
- Documentation of current treatment plans, assessment of the member's care plan goals/objectives and post-hospitalization coordination of outpatient treatment
- Informing provider offices about the availability of Case Management Services through:
  - Provider relations representative visits to provider offices
  - Web site information and resource links
  - Chief Medical Officer communications
  - Case management contacts and direct support to providers in identifying members needs and barriers to care
  - One-on-one coaching and distribution of materials that support members' prenatal and postpartum self care

Outcomes

Aetna Better Health's case management programs have yielded positive results in our programs across the country. Examples of system improvements and positive health outcomes resulting from our case management program include:

- Decrease in ED visits for members with CHF.
- 70% of our Aged, Blind, and Disabled members served by our Arizona program live in home and community based settings.
- Hospital length of stay has continued to decline from 3 days in 2006 to 2.4 days in 2010 as a result of the collaboration between our concurrent review nurses and case managers.
- ED visits continue to show a steady decline from 2007-2009.
- EPSDT rates continue to improve with case management assistance in addressing EPSDT issues with members, as appropriate
- Both timeliness of prenatal care and postpartum care for Missouri Care members scored at the 90th percentile for Medicaid HEDIS.

AREA OF INTEREST 11: REDUCTION IN RACIAL AND ETHNIC DISPARITIES

Aetna Better Health is on the forefront in terms of developing initiatives to reduce racial and ethnic disparities to improve health status. We have implemented programs and services across the nation to reduce racial and ethnic health care disparities and improve health status of our members. Reducing racial and ethnic health care disparities means breaking down barriers, overcoming health illiteracy issues, delivering member-centered care and improving the quality of care provided to members. In short, Aetna Better Health is committed to see that our members, from all racial, ethnic and cultural backgrounds, receive equitable and effective treatment in a culturally and linguistically appropriate manner.

Ethnic, cultural and linguistically diverse individuals and groups face many challenges and barriers to taking full advantage of their health benefits. This is why we employ a systematic approach to designing our service delivery system and programs so that our materials, policies, training programs (internal personnel and external providers) and member services support and enable effectively working cross-culturally. Our experience at Aetna Better Health and our affiliated Medicaid managed care programs is that the single most effective way to reduce racial and ethnic health disparities is through the coordinated delivery of member-centered care. Our Case Management and Disease Management Programs address social needs, health illiteracy, environmental factors, and living conditions that can negatively impact the health status of our members.

Aetna Better Health's medical management model employs a fully integrated approach to care in an effort to address not only a member's physical, behavioral health and substance abuse care needs, but also his/her social, cultural, financial, environmental, psychosocial and vocational circumstances as well. Our care management team brings together and coordinates community-based organizations, informal support systems and health care providers to coordinate quality health care outcomes for our members. We do this through staff education, language interpreters, use of easy-to-follow processes and member and provider materials that assist in improving health care literacy and cultural and linguistic competency.

To reduce racial and ethnic health disparities of health care, Aetna Better Health combines knowledge, clinical skills and behaviors that have proven their effectiveness in promoting positive health outcomes. It is our experience that culture has a profound impact on how people respond to preventive intervention and health services, as well as in how they experience illness, how they access care and the process of getting well. Consistency in design and execution is central to Aetna Better Health's cultural competency programs, including delivery of coordinated health care services, education of members and providers and making important information available in appropriate languages and at appropriate comprehension and literacy levels. Our commitment to communicating, using appropriate language for the member and the situation, includes providing information, written notices, verbal information and descriptions of our grievance and appeal resolution processes in a culturally and linguistically sensitive manner. Our grievance and appeals processes, and overall Member Services Program is designed to identify, prevent and resolve potential cross-cultural grievance and appeals by members. As described below, this includes a cultural sensitivity training program for providers.

Aetna Better Health maintains cultural competency initiatives to address a member's specific cultural and language needs that might challenge the member's ability to access care or understand healthy practices that lead to optimum health outcomes. Our efforts include:

- Monitoring member demographics to identify the need to provide written materials (e.g., Member Handbook, mailings, informational communications) in a second language
- Providing members and health care professionals with access to interpretive and sign language services
- Educating Aetna Better Health personnel who have direct contact with members to promote understanding of and respect for cultural differences and develop services to better meet the needs of diverse populations
- Monitoring the practices of providers as they relate to treatment of a culturally and linguistically diverse membership

Providing language and interpretive services is one element in our strategy to overcome language and cultural barriers. It is our standard operating protocol that our providers and personnel (including but not limited to Member Services, Grievance and Appeals, Care Coordination, Case Management and Disease Management) provide our members with respectful, understandable, culturally sensitive and effective care that is responsive to the member's cultural health beliefs and practices and preferred language. Aetna Better Health provides verbal information, written notices and member materials in the member's preferred language, including informing members of their rights to receive language assistance services.

100% of our Member Services representatives employed by our Texas affiliate are bilingual in English and Spanish

Aetna Better Health has taken the following steps to promote the delivery of services in a culturally competent manner to all members, including those with Limited English Proficiency and diverse cultural and ethnic backgrounds, including:

- Assessment of the number of members by primary language spoken
- Translated (or made available) materials in Spanish on the following topics:
  - Member Handbook
  - "Your Pregnancy" Booklet
  - "You and Your Baby" Booklet
  - EPSDT Reminder Postcards
  - Lead prevention/education materials
- Provided mandatory staff training on cultural competency
- Made interpreter services available to members calling Informed Health Line's 24-hour-day nurse advice line
- Tracking the number of members who speak a language other than English

Aetna Better Health also makes Welcome Calls to our new members. If a member or household identifies Spanish as his/her primary language during the call, a Spanish-translation Member Handbook is mailed to the member.

Our programs to reduce racial and ethnic health care disparities are based on our experience that there is a direct connection between cultural and linguistic competency, health literacy and promoting understanding of barriers to care and services. We see that languages spoken by our PCP, OB/GYNs and specialists are part of our network listing; this makes it easy for the member to locate a provider that is a linguistic match. We have seen that when there is a linguistic match between a member and provider, there is often a cultural connection. Interpreter services are immediately available at no cost to our members and providers and without an appointment. This is a valuable service and we continue to reach out to providers and members to increase awareness. Our employees attend mandatory initial and ongoing training on cultural and ethnic barriers to care.

Aetna Better Health Personnel Training

Recognizing the influence that ethnicity, race and culture have on a member's health outcomes is a critical aspect of our training initiatives and program. We include an effective health literacy and cultural competency training program as a component of our employee orientation and each employee it required to attend an annual update training course. We require that personnel, regardless of level, assignment, responsibility or unit, receive ongoing education and training regarding cultural and linguistic requirements of health care and service delivery supportive (Member Services and Grievance and Appeals support).

Cultural competency training is provided periodically to all employees throughout the year. We target specific cultural competency training to job specific training. Employees are educated on member ethnicity and languages spoken by our members, as well as the impact on health outcomes related to racial and ethnic disparities. This critical piece of training is interactive and employees gain knowledge of racial and ethnic disparities to care. For instance, the focus of training for our member service representatives includes, but is not limited to:

- Accessing translator services
- Health care disparities for racial and ethnic minorities
- How to connect a physician's office with translator services (including what to do if the time to connect is excessive)
- How to translate a care plan, consent form and other documents into the member's preferred language
- Cross-cultural health diversity and the impact on the physician's office and the member
- How to work with members that have Limited English Proficiency
- Directions for frequently ordered tests in languages other than English and sign language

Through our Service Improvement Committee, we review regional demographic and cultural statistics. We assess if we have the appropriate network that would meet the needs of our population for services and linguistic and cultural needs. Our personnel receive initial and ongoing training on cultural competency and are also trained on the community resources that

are available for our members. Aetna Better Health provides translation and educational material to members upon request along with community resources.

Provider Training and Education

Aetna Better Health assists providers in responding to the diverse needs of our membership by providing information through a variety of channels, including, but not limited to:

- Care Management Activities: Our care management personnel (case and disease managers) assess and stratify members based on their individual needs. Through this process, we identify members who have special health care needs and collaboratively develop an individual care plan and work closely with members and their providers to facilitate the coordination and delivery of care.
- Provider Meetings: Our Provider Services personnel conduct regular visits to network providers' offices to discuss various topics, including racial, ethnic, cultural and linguistic and other specific needs of our membership.
- Provider Manual: Aetna Better Health's Provider Manual includes information about the tools that we make available to enhance provider-member communications. For example, the manual contains information about services for members with Limited English Proficiency and/or hearing disabilities and how we can assist in overcoming barriers to effective communication (e.g., Language Line®, TTY line). We also include a link to the Provider Manual on our Web site.
- Interaction with Medical Management: Regularly scheduled and ad hoc interactions between Aetna Better Health and our network providers present a valuable opportunity to see that our members' unique needs are met.
- Provider Directory: Our Provider Directory indicates whether providers speak languages other than English. Our Web site includes a link to a continuously updated edition of our Provider Directory.

To further demonstrate our commitment to reducing racial and ethnic disparities, our Aetna Better Health Texas Plan recruits and hires 100% bilingual Member Services personnel who work at home in local communities, making them effective advocates for the members we serve.

Aetna Better Health's commitment to reducing disparities further extends to the recent acquisition of Schaller Anderson, LLC, an organization known for its high quality health management of the Medicaid population in multiple states. Examples include:

- Evaluating drug interactions, unsafe medications and access to medications for the poorest populations in America
- Using HEDIS program data to eliminate disparities in preventive care access for:
  - Women who have never had a Pap smear or mammogram
  - Children who have been to the ED many times per year because of poor asthma care
  - Men who have received little to no care for their diabetes prior to an amputation
  - Members with sickle cell disease who have not had a flu shot
- Monitoring ED use as a measure of access

- Measuring behavioral health co-morbidity and co-managing these members in care management
- Profiling provider practices to deliver access to care

AREA OF INTEREST 11: HOSPITAL READMISSIONS AND AVOIDABLE ADMISSIONS

Aetna Better Health recognizes that members have better outcomes when they establish a relationship with a PCP as their PCMH. It is our experience that members who visit their PCPs within 3 days of discharge from a hospital setting are less likely to be readmitted to the hospital for the same condition. To facilitate the member-PCP relationship, we initiated an impactable admissions program in each of our affiliated health plans. We believe that by engaging members and their families to play an active role in their health care, assisting the member in navigating the delivery system, and coordinating care between service providers and service, setting, we can improve member health outcomes and reduce unnecessary costs associated with avoidable hospitalizations and readmissions.

Aetna Better Health has in place a number of programs and initiatives designed to effectively and appropriately control avoidable hospitalizations and hospital readmissions (impactable admissions). We define impactable admissions as those disorders and diagnoses which afford an opportunity for more optimal management either before admission, during the hospital stay or after discharge (so as to reduce the risk of readmission). Our focus is to provide for the admission of members who need hospitalization while identifying and managing those who would benefit from other alternatives (e.g., out-patient, step-down, short stay, observation, home care, etc).

Aetna Better Health's impactable admissions program reduced avoidable admissions by 10%.

Aetna Better Health recognizes that many hospital admissions result from an ED visit. To address this, we initiated an impactable admissions program in each of our health plans that evaluates identified ambulatory sensitive conditions and targets a reduction for inappropriate hospital admissions for regularly occurring diagnoses such as asthma, diabetes, vomiting/GI illnesses, cellulitis, etc. To accomplish this, we designed a root cause analysis detailing the possible causes of admission for each diagnosis and then implemented interventions designed to reduce unnecessary utilization, including reduced ED usage.

Aetna Better Health, and our affiliated health plans expanded its interventions based on the specific needs of our members across the nation, and to address barriers impacting reductions in hospitalizations and readmissions, by:

- Educating PCPs on evidence-based guidelines and best practices
- Meeting with ED physicians to discuss alternative approaches to promoting primary care within the ED
- Developing targeted care plans for hospitalized members to facilitate access to ambulatory care services
- Monitoring the availability of PCP after hours coverage
- Identifying patients with co-morbid physical and behavioral conditions with the highest use of the ED and hospitals and developing targeted case plans

- Targeting network expansion to increase the number of PCPs with after hours coverage
- Expanding our network of more cost-effective urgent care providers
- Developing protocols for identifying and managing members who present at the ED with the intention of obtaining narcotics or other pharmaceuticals subject to abuse (e.g., Recipient Lock-in Program)
- Referring members accessing EDs for the purpose of obtaining medications subject to abuse for substance abuse or pain management services
- Case management collaboration with behavioral health providers to co-manage- members with behavioral health conditions
- Addressing member-specific issues such as lack of transportation or language barriers
- Educating members on available disease and chronic care management programs
- Requiring providers to have an on-call system which requires providers to either respond directly to the member within 30 minutes, or have a qualified medical professional available who will respond within that timeframe.

All of our health plans are intervening at the member level to implement substantive interventions to reduce inappropriate ED utilization, such as co-case management of their behavioral conditions (with BH-MCOs) and to address transportation, language or other barriers to accessing care. Examples of these interventions include:

- One Health Plan reviewed doctor visits immediately prior to an ED visit and found that some doctors were not fully adhering to evidence-based guidelines, resulting in poor after hours care. The Plan educated the provider on the content and importance of following evidence based guidelines and followed up to assess ongoing adherence.
- Another Plan met with ED physicians to discuss alternative approaches within the ED to promote primary care.
- Still another plan reviewed all ED and hospital utilization for all currently hospitalized patients and developed plans of care that enhanced access.

We are closely monitoring trends within this targeted population and sharing best practices throughout our organization. Going forward, Aetna Better Health is focused on those members who have co-morbid physical and behavioral conditions and who are high users of hospital services, including ED services. Each month we review data for ED utilization at each of our health plans and develop appropriate intervention strategies to address identified trends.

In its first year, Aetna Better Health's Impactable Admissions Program (IAP) achieved an overall 10 percent reduction in avoidable admissions (ranging from 3 percent to 21 percent across eight health plans), resulting in both significant savings and improvements in quality of care. In the process, readmissions were also decreased by 2 percent.

Readmissions Program

Aetna Better Health believes that preventable admissions can be further reduced by increasing the percentage of members with a successful discharge from the hospital. To that end, we have developed a Readmissions program to assist members in accessing ambulatory care upon discharge. The premise of our program is that readmission prevention begins within a day of

admission, not on the day of discharge, and should address the root causes that led to the current admission. Through this program, our affiliated plans designate personnel, or teams of personnel to facilitate comprehensive discharge planning with the member and the member's family and/or caregivers, as appropriate.

Consist with our belief that discharge planning should begin at the time of admission, designated Aetna Better Health personnel take the following steps prior to the member's discharge date:

- Schedule follow-up visits with PCP/PCMH, specialist(s), BH, tests, and/or laboratories as necessary
- Document key discharge information
  - Information about current admission, including tests/lab results
  - Medication summary including dosage, frequency and reason
  - Diet and exercise plans
  - Contact information for Discharge Advocate and member's case manager if applicable
  - Dates and times for scheduled follow-up visits with PCP/PCMH, specialist(s), BH, tests, and/or laboratories
  - "Red Flags" for the member to watch out for and plan for action
  - Checklist to confirm that member understands discharge instructions (confirm understanding by using teach back method)

On the day of discharge, designated personnel provide post-discharge training with the member and their family/caregiver to explain any discharge instructions and paperwork, and answer any questions they may have. Within 72 hours after discharge, we conduct a telephonic or home visit and conduct an assessment to identify the member's needs for:

- DME
- Transportation
- Social Services
- Home Health
- Medications reconciliation
- ADL evaluation
- Confirm available support system – caregiver, family
- Depression screening, safety/fall evaluation (for certain members)
- Educations provided (verbal or printed materials if necessary)

We continue to reach out to the member as clinically indicated to prevent readmission (evidence based information suggests at least once weekly for 30 days) to follow up on any needs identified in the Needs Assessment, identify any additional needs based on changes in the member's status, provide education, and coordinate care with the member's PCP/specialist as needed.

As part of our QAPI program, Aetna Better Health reviews 30 day readmission rates on a monthly basis to measure the success of interventions and determine the need to take additional

actions. Successful interventions are incorporated into our ongoing QAPI program and best practices are shared across all of our health plans.

Aetna Foundation

In addition to the clinical initiatives implemented by our network of Aetna Better Health affiliated health plans across the nation, the Aetna Foundation has partnered with numerous organizations across the country to improve member health outcomes associated with immediate issues facing our population, including obesity and racial disparities in health care. In an effort to garner insight into the root causes of the problem and determine which course of action has the greatest potential for success, the Aetna Foundation has made numerous grants to organizations throughout the country. It is our expectation that the work of these organizations will lead to the establishment of best practices. Following is a brief summary of the types of initiatives the Aetna Foundation is funding.

Grants to Organizations Impacting Childhood Obesity

The Aetna Foundation supports local community organizations with grant monies to design and implement programs to reduce childhood obesity. Our current grant recipients include:

Penrose School of Philadelphia: Using a $30,000 grant, the Penrose School will design and implement year-round fitness programs that encourage healthy behaviors among children in a medically underserved area of Philadelphia. The school will especially target children who are obese or at risk of becoming obese.

Carl and Emily Weller Center for Health Education: A $30,000 grant to the Center to help fund the "Food and Fitness for Life" program, which will facilitate obesity education to pediatricians and families in the Easton, PA area. The program aims to engage 2,700 students in grades 2 through 4.

Our Lady of Lourdes Foundation: A $40,000 grant will support the Foundation's obesity prevention program for at-risk Hispanic newborns and toddlers in families receiving prenatal care at the Osborn Family Health Center in Camden, NJ.

The Seton Fund of the Daughters of Charity of St. Vincent de Paul: A $30,000 grant for its "Healthy Kids – Healthy Families" program to address childhood obesity and type 2 diabetes among children in Austin, TX.

Cook Children's Physician Network: A $27,000 grant to support its Fit Families Intervention program for morbidly overweight and obese children.

University of Texas Health Science Center at Houston: A $25,000 grant for its Games for Wellness project to address childhood obesity.

Going forward, Aetna Better Health's goal is to continue to expand our efforts in addressing childhood obesity based on identified best practices from the many pilot initiatives and projects operating around the country. Our experience tells us that continuous follow-up is essential to the long term success of these programs and greatly increases our ability to achieve improved physical fitness, nutritionally sound eating habits and the maintenance of a healthy weight among our nation's children.

Aetna Foundation's efforts to reduce racial and ethnic disparities

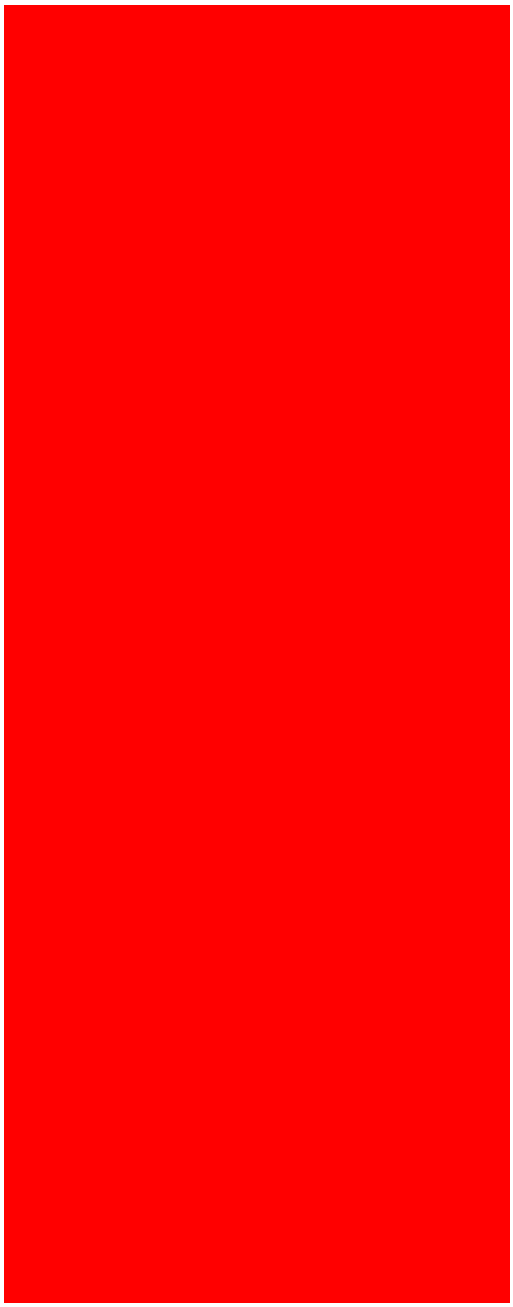
Aetna Better Health's corporate parent, Aetna, is on the vanguard of efforts to assess and track racial and ethnic disparities in health care and to develop interventions that will improve the quality of care for minority members. Aetna has made cultural competency one if its priorities. Since 2001, Aetna and the Aetna Foundation have awarded over $15.5 million (including $5.5 million in 2006) for programs addressing health-related racial and ethnic disparities, these programs are operational for our commercial line of business. In fact, Aetna was the first national insurer to collect racial and ethnic information which reflects our commitment to use this information to better understand and address identified disparities.

In 2007, NCQA, through its program Recognizing Innovation in Multicultural Health Care, identified and recognized Aetna for its Breast Health Ethnic Disparity Initiative and Research Study. NCQA found that Aetna's program was innovative and added to the evidence base of effective methods for addressing culturally and linguistically appropriate services (CLAS) and disparities. Examples of the Aetna Foundation's current initiatives to address health care disparities include:

- Morehouse School of Medicine – "Improving Diabetes Care through Technology and Infrastructure Enhancement" to improve care among low-income, inner city adults
- College of New Rochelle – "Weight and Wellness Module Education" to provide timely information about the health risks associated with obesity
- Centre for Asian and Pacific Islanders – "First Words for Family Health" program to help immigrants and refugees to safely utilize and understand American health care.
- African-American Diabetes Education Pilot
- Study of Hypertension in African-Americans

Going forward, Aetna intends to work in partnership with Johnson & Johnson and Merck to expand its Diabetes Program to the Latino population. Aetna is also collaborating with GlaxoSmithKline to improve health literacy among asthmatic members. As appropriate, Aetna Better Health will incorporate what Aetna learns from these programs into our operations.

86 J.2



J.2 Describe the policies and procedures you have in place to reduce health care associated infection, medical errors, preventable serious adverse events (never events) and unnecessary and ineffective performance in these areas.

Patient Safety/Error Reduction Overview

Aetna Better Health is acutely aware of the alarming statistics related to patient safety and has worked with agencies, consumer groups, advocacy organizations and other stakeholders to promote an increased awareness of the problem and to develop pragmatic, affordable solutions. We are committed to promoting patient safety and reducing or eliminating medication errors, reducing preventable errors and removing the delivery of unnecessary and ineffective care. This commitment is widespread throughout the organization and is demonstrated in our policies and procedures, provider contracts, staff training program, quality management processes, claims processing, and partnerships with key stakeholders.

Aetna Better Health stipulates in our hospital contracts that we will not pay for or allow members to be billed for any of the 28 National Quality Foundation (NQF) endorsed "never events." In addition, our contracts incorporate language that requires hospitals to: 1) report the events to at least one specified agency within 10 working days (e.g. JCAHO, Aetna Better Health Quality Management Department, patient safety organization); 2) take action to prevent future events; 3) waive all costs related to the event, and, 4) apologize to the affected patient and family. Aetna Better Health also requires providers to notify us of "never events" by contacting our Quality Management Department, or submitting information through a secure web portal. We notify providers of these requirements at least 30 days prior to the effective date of the program or their contract, and through the provider handbook, and on our website. Aetna Better Health's Provider Network, Quality Management, Claims and Grievance and Appeals Departments work collaboratively to monitor provider adherence to these requirements. It is our policy to refer any claims that include diagnostic codes associated with "never events" to our Quality Management (QM) Department for review for potential quality of care concerns. Aetna Better Health will not reimburse providers for claims associated with "never events".

The goal of Aetna Better Health's leadership is to allocate adequate resources for training and education necessary for all personnel to appropriately identify and refer sentinel events. We have written policies and procedures that require all personnel having any contact with members or providers (e.g., Case Managers, Provider Services, Utilization Management, and Member Services) to attend new employee training and annual training on how to identify and refer sentinel events to our QM Department. Aetna Better Health provides training and ongoing employee education so that new and current personnel have an introduction to the principles of quality management and develop the necessary skills and knowledge to effectively recognize sentinel events and make timely and appropriate referrals to the QM Department. By maximizing the opportunities for identifying quality of care concerns, we successfully achieve our goal to provide our members with optimal quality of care and services.

Aetna Better Health's comprehensive training program includes both mandatory general training for all Aetna Better Health personnel as well as more targeted required training for employees that are more likely to encounter quality of care and services concerns (e.g., Case managers,

Provider Services, Utilization Management, and Member Services personnel). Our training modules include compliance requirements, HIPAA/member confidentiality, member rights, keys to identifying quality of care concerns, the role of the QM Department and that each employee must be dedicated to protect the rights and best interest of our members.

To further support training efforts, Aetna Better Health utilizes a one page list of potential quality of care concern triggers that includes examples of the sentinel events and types of quality of care issues that must be immediately referred to QM. This list is widely distributed among personnel as a desktop reference for daily use and its use is reinforced by managers and supervisors. In addition to the general overview training mandatory for all employees, personnel likely to encounter sentinel events in performing their jobs will receive advanced and comprehensive instruction on the recognition of quality of care and service concerns and the process for referring these events to our QM Department. Personnel involved in this required training are from our Case Management, Provider Services, Utilization Management, and Member Services areas. This targeted training reinforces and advances the general training module provided to all Aetna Better Health employees and include specific training modules for both clinical and non-clinical personnel. Failure to complete these training modules results in disciplinary action that may include dismissal.

To further underscore our commitment to reducing health care associated infections, medical errors, preventable serious adverse events (never events) and unnecessary and ineffective performance in these areas, our patient safety/error reduction policies and procedures includes ambulatory medical record reviews and peer review initiatives.

Aetna Better Health's concurrent review nurses are our first line of defense for detecting potential "never events". The concurrent review nurse reviews the member's medical record electronically or on-site, and is in a good position to detect "never events". Should the concurrent review nurse detect a possible "never event", they will refer the situation to Aetna Better Health's QM Department for follow up and review. The QM Department will advise our Claims Department of the potential "never event" so that the claim may be pended upon receipt for further review. The concurrent review nurse shall also advise the hospital of the situation and that the QM Department will conduct further review.

Ambulatory Medical Record Review (AMRR)

Aetna Better Health identifies opportunities to address unnecessary and ineffective performance related to sentinel events by performing Ambulatory Medical Record Reviews (AMRR) with primary care providers. The idea of this policy and procedure is to make sure that records reflect sound approaches to members' evaluations and care plans, and that any concerns related to what is charted are moved up to a quality review level to be addressed for possible corrective actions. To accomplish this, Aetna Better Health has systems in place to perform the following functions:

- Identify gaps in quality (effectiveness) and/or efficiency
- Perform data analysis to clearly define root causes and design appropriate solutions
- Implement analysis and needed corrective action plans
- Closely monitor results and make any needed revisions occur

Peer Review Initiatives

Aetna Better Health's standard operating procedures establishes processes whereby we proactively identify and address any potential quality of care concerns and take action, as appropriate. We have a state-of-the art data system to track provider potential quality of care concerns across all lines of business (Commercial, Medicaid, Medicare). This allows us to quickly identify potential quality of care concerns related to specific providers serving multiple programs.

Under the direction of the Chief Medical Officer (CMO), Aetna Better Health's National Quality Management Department generates weekly reports to identify providers involved with potential quality of care concerns. Providers with greater than two (2) potential quality of care concerns across all business lines within the previous twelve (12) months are automatically referred to the Credentialing and Performance Committee (CPC) for peer review. Chaired by the Aetna Medical Director, the CPC includes local network practitioners. The CPC has decision making authority and may initiate professional review activities involving the professional competence or conduct of practitioners whose conduct adversely affects, or could adversely affect, the health or welfare of members. Upon review of the incidents, the CPC may take the following actions:

- Request additional information
- Recommend that the CMO take actions, which may include, but are not limited to the following:
  - *Peer contact:* The Committee may recommend that the CMO or a designated Medical Director contact the provider to obtain additional information or discuss the committee's action.
  - *Education:* The Committee may recommend that the Plan sends information or educational material to the provider or that the provider seek additional training.
  - *Committee appearance:* The Committee may recommend that the provider attend a committee meeting to discuss the issue with committee members.
  - *Credentials action:* The Committee may recommend that all Aetna Better Health affiliated plans contracted with the provider reduce, restrict, suspend, or terminate the provider's credentials necessary to treat members as a participating provider.
  - *Corrective Action:* The Committee may recommend that all Aetna Better Health affiliated plans contracted with the provider limit the provider's new member enrollment, issue sanctions, or require other corrective action.

All Aetna Better Health affiliated plans contracted with the provider, across all lines of business are notified of the outcome of the peer review. If the provider is terminated from participation with Aetna Better Health, they are terminated across all lines of business.

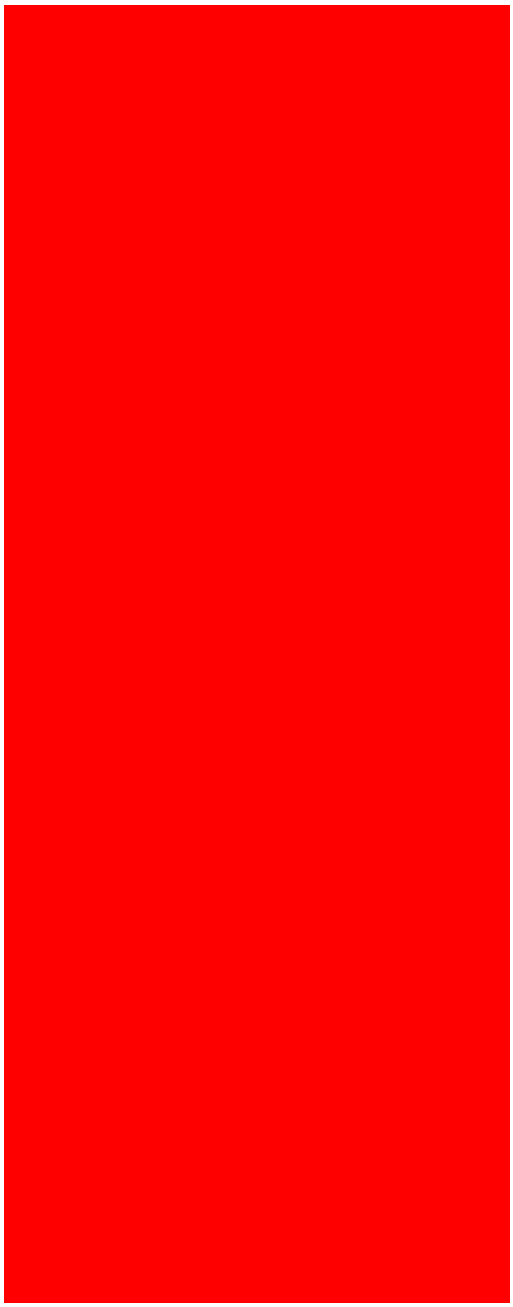
Under our Practitioner Participation and Peer Review policy and procedure, Aetna Better Health also looks for any activities which cause harm or place members at risk, or potential risk. Records may be peer reviewed in many fashions, from the formal Peer Review Session by the CPC to routine daily monitoring. The Quality Management Department analyzes many cases monthly for any risk of suboptimal care, and when necessary refers practitioners to the CPC who is responsible to set corrective actions for providers from basic educational requirements to

reports to the appropriate state oversight authority and the National Provider Database. In past cases, this has resulted in improved nursing home safety, better care approaches to certain medical conditions, increased observation after procedures in certain conditions, improvements in hospital quality and safety surveillance systems, and other positive gains.

The Leapfrog Group

Aetna Better Health is committed to providing quality care and maintaining the safety of its members. To that end, we have adopted comprehensive policies to reduce health care associated infection, medical errors and preventable serious adverse events, including the twenty-eight (28) "never events" endorsed by the National Quality Forum. We are proud to be the very first nationwide health insurance plan to establish a joint hospital incentive and reward program with the Leapfrog Group (Leapfrog). We are also the first health plan to endorse Leapfrog's innovative approach to addressing "never events," including public recognition of hospitals that voluntarily develop effective procedures for monitoring and reporting these events. We also make patient safety information and tools available to members on our Web site. We look forward to the prospect of our Louisiana members enjoying the improved outcomes we expect this initiative to produce.

87 J.3



J.3 Describe how you will identify quality improvement opportunities. Describe the process that will be utilized to select a performance improvement project, and the process to be utilized to improve care or services. Include information on how interventions will be evaluated for effectiveness. Identify proposed members of the Quality Assessment Committee.

Identifying Opportunities for Quality Improvements

Aetna Better Health, together with its affiliates, has been providing high quality, efficient and effective Medicaid managed care services for over 25 years. We have built on this successful history of establishing and maintaining high quality standards for our operations and networks. Our experience includes sustaining continuous quality and process improvement in our clinical and operational programs that result in changing the way our members view their health and their role in achieving and maintaining positive health outcomes. This leads to increases in member and provider satisfaction. It is our experience that states expect Aetna Better Health to design, establish, maintain, measure and systematically report outcomes of our quality management program.

We gather accurate, timely, and relevant information about quality of our operational, administrative and healthcare delivery through our provider network. We focus on gathering and analyzing data to determine favorable and unfavorable quality patterns because this information is vital to our ability to successfully develop interventions to improve health outcomes and manage utilization of covered and medically necessary services. Our Board of Directors (the Board) is ultimately responsible for all aspects of our quality management program, including medical management. This responsibility includes the evaluation and oversight of the efficiency, effectiveness and outcomes of the QAPI program. The Board provides strategic management direction to our QAPI program and evaluates the degree that the philosophy and scope of the QAPI program is incorporated within each operational/management unit and across Aetna Better Health's operations. The Board delegates authority to Aetna Better Health Chief Executive Officer (CEO) to develop and administer our quality management program, including medical management. The CEO delegates authority and responsibility to our Chief Medical Officer (CMO) to execute all aspects of our QAPI program. The CMO will have responsibility, accountability, and authority for directing the development and implementation of the QAPI program. Our QAPI program will receive feedback from our members and providers to continuously improve our programs, operations, and management approach. These program, operational, and management improvements will lead to enhanced member health outcomes and efficiency of provider services. Our CMO will have the support of our Aetna Medicaid Business Unit corporate medical management personnel, Information Technology (IT), Informatics, and Actuarial Services to continually strengthen and improve our ability to develop, implement, monitor/evaluate, and replicate successful interventions to improve health outcomes and quality of care. We consider the collection of accurate, timely, and complete quality management data and results of clinical performance measures to be pivotal to developing successful interventions to improve health outcomes and quality of care.

The foundation of our Quality Assessment and Performance Improvement (QAPI) program is our QAPI Plan. The QAPI Plan will support Aetna Better Health's strategic plan and goals, the Department of Health and Hospital's quality strategy, quality plan and other requirements of the Aetna Better Health contract. Annually reviewed and approved by our Board, the QAPI plan provides the administrative and functional framework for our quality and performance improvement activities, including but not limited to:

- Identifying and selecting Performance Improvement Project (PIP) topics
- Inter-department communication, cooperation, and coordination
- Evaluating effectiveness of our interventions; and
- Guiding our processes for assessing clinical and non-clinical processes.

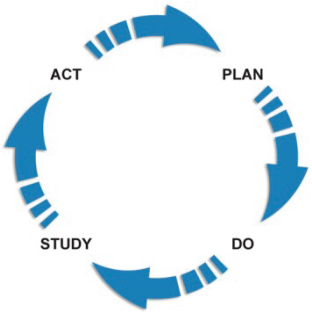
Aetna Better Health designs it QAPI program, consistent with our ten other Medicaid managed care contracts, to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promotes improved patient outcomes through monitoring and evaluation activities. Our QAPI plan provides a coordinated strategy for implementing the QAPI program, including our structure for decision-making, developing and implementing interventions and assessing of results. The plan also provides the framework for communicating QAPI program goals throughout the organization including personnel training and organization. Through the plan we define our processes and approach toward for our QAPI program, including our methods for evaluating the effectiveness and impact of our QAPI program, and incorporating feedback from members, providers, and other stakeholders into the development of our QAPI program.

Based on the structure, through our program we define, identify, and implement improvement activities to enhance our clinical and program efficiency, provide effective utilization and identify opportunities to improve outcome management to achieve meaningful advancement of our quality goals. Improvement methods include, but are not limited to, performance improvement projects, medical record audits, performance measures, and surveys. Additionally, Aetna Better Health's QAPI program is designed to:

1) Detect patterns of underutilization and overutilization of services, and
2) Assess the quality and appropriateness of care furnished to members with special health care needs.

The QAPI Program's written policies and procedures address components of effective healthcare management and define processes for ongoing monitoring and evaluation that promote quality of care. Aetna Better Health's underlying strategy will focus on continuous improvement and allow us to rapidly intervene when data monitoring reveals inconsistencies in care, or responding to member or provider concerns. It is our standard operating procedure to prioritize high risk and high volume areas of patient care in selecting QAPI activities.

Aetna Better Health uses the Plan-Do-Study-Act (PDSA) model to assess our processes for tracking, trending, analyzing, and acting upon performance measure, and surveillance data. Our PDSA approach involves leadership from Aetna Better Health's entire organization. The PDSA model for continuous improvement provides the framework for our approach to developing and implementing interventions through the following steps:



1. Plan. Recognize an opportunity and plan a change.
2. Do. Test the change. Carry out a small-scale study.
3. Study. Review the test, analyze the results and identify what we've learned.
4. Act. Take action based on what you learned in the study step: If the change did not work, go through the cycle again with a different plan. We will incorporate successful interventions into ongoing systems, and use what we learned to plan new improvements, beginning the cycle again.

Quality management is a company-wide endeavor with our CMO leading the integration of interdepartmental monitoring processes and activities (such as those for referring quality of care/risk issues, member/practitioner complaints, grievances and appeals), business application systems and databases across each functional or operational unit. Our quality program includes a structure of oversight committees with representation from across Aetna Better Health and includes community providers and members. Functional program areas and all our formal committees actively participate in identifying opportunities for quality improvement, by individual member or provider and at the health plan level. The foundation of Aetna Better Health's processes will be to enhance and implement our QAPI opportunities and interventions by establishing, reinforcing, and facilitating a cross-functional approach through leadership from our senior management team and consistent internal communication about QAPI activities through the committee structure.

Our executive leadership and management team responsible for Medical Management, Member Services, Utilization Management (prior authorization, concurrent review, and retrospective review), Grievance and Appeals, Compliance, Case Management, Network Development and Contracting, and Provider Services will be responsible for disseminating, orientating, and training personnel about the value and importance of our QAPI programs, activities and outcomes. As part of the required annual performance assessment, we evaluate and document strategies, activities, communication, and feedback that each segment of the management team contributed to Aetna Better Health QAPI program.

Role and Membership of Aetna Better Health's QM/UM Committee

The Quality Management/Utilization Management Committee (QM/UM) chaired by the CMO, serves as an integrating forum where key personnel from all functional areas within the organization systematically review data, identify opportunities for improvement, make recommendations for system enhancements and process improvements, and track initiatives to completion. The QM/UM Committee meets quarterly and is responsible for the identification of quality improvement opportunities, the finalization of intervention strategies to improve quality and cost effectiveness across the continuum of care, and integration of the QAPI program throughout the organization. The QM/UM Committee is critical to our programs for members with special health care needs (MSHCN), including children with special health care needs (CSHCN). The QM/UM Committee reviews outcomes from programs for MSCHN and CSHCN within our membership and utilization patterns. The QM/UM Committee continually evaluates,

reviews, and makes modifications to the MSHCN and CSHCN programs. Outcomes of the QM/UM Committee activities and actions are reported to the Board. The QM/UM Committee, chaired by the CMO and the membership includes the:

- Chief Executive Officer (CEO),
- Chief Operating Officer (COO),
- Quality Management Coordinator,
- Utilization Management Coordinator,
- Directors and Managers from Medical Management, Performance/Quality Improvement Coordinator
- Aetna Better Health's Medical Directors
- Representation of contracted providers from local communities where we have enrolled members and
- The CMO and the CEO will review and determine, within 30 days of contract award, the potential of including a representative from a member advocacy group to our QM/UM committee.

The QM/UM Committee will designate a member to participate in Department of Health and Hospitals (DHH) Quality Committee meetings and provide a report back to the Committee. Aetna Better Health maintains minutes of all QM/UM Committee meetings, and will submit these minutes to DHH within 10 days following each meeting. Aetna Better Health will incorporate this documentation as well as findings and recommendations based on our data review into our annual evaluation of the effectiveness of our QAPI program and care management activities. The QM/UM Committee reviews and approves the annual QAPI program evaluation prior to submission to DHH.

The data reviewed by the QM/UM Committee includes:

Findings from Internal Program Assessments

Aetna Better Health conducts a number of formal assessments/reviews of its program operations and subcontractors to identify opportunities for improvement. This includes, but is not limited to:

- Ambulatory medical record reviews of contracted providers,
- Credentialing/re-credentialing of providers,
- Oversight reviews of delegated activities,
- Inter-rater reliability audits of medical review personnel,
- Annual quality management program evaluation,
- Cultural competency assessment and
- Assessment of provider accessibility and availability.

Clinical and Non-Clinical Performance Measure Results

Aetna Better Health uses an array of clinical and non-clinical performance standards (e.g., HEDIS®[2], call center response times, claim payment turnaround times, grievance and appeals

[2] HEDIS® is a registered trademark of the National Committee for Quality Assurance.

turnaround time) to monitor and evaluate member outcomes including but not limited to areas such as:

- Access and availability of care
- Effectiveness of care,
- Use of services
- Prevention measures

Through key management reports (e.g., key indicator report, pharmacy analysis report, HEDIS rolling 12 month performance indicator report, claims dashboard, member grievance report) we monitor our compliance with these standards to establish targeted benchmarks (e.g., performance goals, NCQA Medicaid HEDIS 75th percentile). Through frequent monitoring and trending of our performance measure results, we are able to identify opportunities for improvement in clinical and operational functions.

Member Profiling

The source data for our member profiling process is claims data. Actuarial Services Data Base (ASDB) supports Aetna Better Health's reporting and analytical capabilities, such as our multidimensional predictive modeling, statistical outlier analysis and member profiling. The application houses eligibility, provider, prior authorization and claims data and serves as a key data source for a diverse user base, including Medical Management, Finance and Operations. Analysts can use the proprietary Actuarial Analytics Web Portal (AAWeb), an interactive interface, as a point-and-click query tool to access reports, drill down into data and export information from ASDB. For instance, AAWeb can generate customized analyses to identify favorable and unfavorable cost and utilization trends, measure performance against key benchmarks, and review summary information. It is a powerful tool that affords our Medical Management personnel access to member and provider profiles, as well as current cost and utilization trends. This gives our Medical Management team the capability to disseminate analysis results on treatment best practices to providers, who can then identify and prevent unnecessary migrations to higher levels of care and the development of chronic health conditions.

Member profiles are generated by Aetna Better Health uses member profiles to:

1) Identify members who have under- or over-utilized health services, including Emergency Department services, hospital admissions and prescribed medications;
2) Identify members who may lack appropriate access to needed services or could benefit from education about how to best utilize the health care system;
3) Target education to Primary Care Providers (PCPs) that do not appear to be following recommended clinical practice guidelines or need to more effectively reach out to their assigned members and facilitate better management of the member's care; and
4) Assist in supporting other internal health plan operations, such as concurrent review decisions, member appeals, and fraud and abuse detection.

This information enables us to identify potential quality and utilization management (over and under utilization). Based on this analysis we make appropriate referrals to specialized care management programs and/or perform corrective interventions with members and/or providers.

Provider Profiling

Aetna Better Health uses provider profiles to identify primary care providers (PCP)/PCMH utilization and/or quality of care issues, as directed by the QM/UM Committee. The objectives of our provider profiles are to:

- Identify PCP, OB/GYN and high volume specialist utilization patterns that vary significantly from peer network practitioner groups;
- Identify trends that can be addressed through PCP, OB/GYN and high volume specialist outreach;
- Provide information to network PCP, OB/GYN and high volume specialist about their practice patterns;
- Safeguard confidentiality by maintaining secure access to the profile interface;
- Provide information to be used as a component of quality management oversight and to
- Provide information to be used as a component of provider incentive compensation.

Across our Aetna Better Health affiliated plans, the provider profiling process has effectively improved PCP/PCMH performance related to well-care visits and behavioral health screenings during standard office visits; increased the use of generic medications; and improved compliance with disease specific clinical practice guidelines. We expect our profiling process in Louisiana to result in similar positive trends.

Data Trending and Pattern Analysis

With our innovative information management systems and data mining tools (see the above discussion on ASDB), Aetna Better Health makes extensive use of data trending and pattern analysis for the identification of opportunities for improvement. We use many sources of data to identify opportunities to improve member health outcomes including potential over- and under-utilization, member and PCP profiles, plan utilization management reports and key indicators, grievance and appeal data, pharmacy reports, provider audits, prior authorization and claim reviews. We monitor and analyze these data and take action to improve health care outcomes, coordinate care for members, and facilitate access to care in the most appropriate setting.

Formal Feedback from External Stakeholder Groups

It is our standard operating procedure to reach out to external stakeholder groups by conducting one-on-one meetings, satisfaction surveys (CAHPS®), focus groups with individuals such as members and families, providers, state and community agencies. Information gleaned from these interactions will be shared with the appropriate functional areas and the QM/UM Committee to identify opportunities to improve processes and health outcomes for our members. As indicated above, our CMO and CEO will, within 30 days of contract award determine the potential of adding a representative from a member advocacy organization to our QM/UM committee. The CEO will advise DHH of our recommended decision.

Other monitoring tools

Aetna Better Health employs several other mechanisms for identifying opportunities for improvement, including, but not limited to: 1) GeoAccess analysis by GSA to identify potential areas to improve accessibility and availability of services; 2) Member-to-PCP ratio that takes into account PCP capacity and panel status; 3) Accessibility standards such as appointment availability, wait time in the office, and phone and after-hours accessibility; 4) Member grievances and provider complaints; 5) Member and provider satisfaction survey data; and 6) Services provided by out of network providers. The results of these monitoring activities will be shared with the appropriate functional area (e.g. Member Services, Provider Relations) and the QM/UM Committee.

Findings from External Program Monitoring and Formal Reviews (EQRO)

Aetna Better Health incorporates the results of externally initiated review activities such as an annual external quality program assessment or issues identified through DHH's ongoing contract monitoring oversight process into our quality management processes. It is our experience that this information is valuable in identifying and addressing operational processes in need of improvement.

Example of Internal Review of Individual Member or Provider Issues

In addition to receiving grievances and appeals from members, providers and other external sources, Aetna Better Health proactively identifies potential quality of care issues for review through our daily operations (e.g., member services, prior authorization, and case management). Through established formal review processes (e.g., grievances, appeals and quality of care), we identify specific opportunities for improving care delivered to individual members.

Example 1

The QM/UM Committee of an affiliated health plan recognized that for many of our most complex members with multiple co morbid conditions, who are discharged to home are often are readmitted to the hospital within 30 days. This pattern results in reduced health outcomes, quality of care, increased utilization, and negatively impacts the member's quality of life. Therefore, the CMO developed a high-intensity, comprehensive, holistic and member-centered clinical CM program to supplement the standard CM program. CMs in this program are all RNs with extensive experience working with the elderly and physically disabled. This readmission prevention program includes the following activities: 1) on-site assessment by the CM at the hospital; 2) in-home visit within 48 hours of discharge for assessment of: a) medication reconciliation; b) DME and home healthcare services as ordered; c) home/family support; d) level of functional screening of physical, cognitive, and behavioral factors; 3) in home or telephonic assessments at 3, 6, 10 and 14 days post discharge; 4) 30 days post discharge assessment of the member to determine if the member's post discharge needs have been met. This voluntary program includes close and constant communication during this critical period between the clinical CM and the member's assigned CM. Currently, this program is in effect at four hospitals. The CMO, reporting to the QM/UM Committee, is evaluating the effectiveness of this program for expansion to other hospitals.

Example 2

Another affiliated health plan identified concerns regarding significant wait times to obtain speech therapist referrals in a specific geographic area. In evaluating the issue, it was determined

that access to speech therapists was a problem. As an immediate response, the affiliated health plan allowed speech therapy services to be authorized on an as needed basis for non-participating providers until they were able to expand the provider network. Subsequently, the health plan added new additional speech therapists as well as physical therapists and occupational therapists to our network to improve accessibility to these services.

Example 3

In another affiliated health plan that includes long-term care, the QM/UM Committee identified an under utilization of PCP appointments as one of the primary contributors to high ED visits. The PCP initiative was designed to increase our members' frequency of visits to their PCP. The goals of the initiative were to improve communication between the member and the member's family/caregiver and the member's PCP, to promote the member's self-awareness of their health status, and to empower the member and the member's family/caregiver to ask the member's PCP questions about their condition and care. The Case Manager (CM) has a major role in the PCP initiative. It is the responsibility of the CM, for their assigned caseload, to promote and increase PCP visits to at least quarterly. This responsibility is part of the CM annual assessment review and performance is part of the CMs' 1:1 meeting with their supervisor. The CM provided the member with a list of urgent care facilities within the member's residence zip code and educated the member and the member's family/caregiver on the appropriate use of the ED and urgent care centers. The CM verifies each quarter, during the in-home quarterly assessment process, that the member visited their PCP during the prior quarter; the member's record is updated in our web-based care management business application (Dynamo™) and in QNXT™ to track the member's progress.

Selecting Performance Improvement Projects

It is our standard operating procedure for each Aetna Better Health programs to have an effective, efficient and ongoing program of performance improvement projects (PIPs) that focus on clinical and nonclinical areas. Our written policies and procedure requires the identification and selection of clinical and non-clinical topics, through continuous data collection and analysis, that affects a significant portion of our members; including MSCHN, CSHCN, high-volume or high-risk conditions and, that leads to improvements in members' health, functional status or satisfaction as a result of the PIP process. We will conduct performance improvement projects (PIPs) in accordance with CMS requirements and develop PIPs in compliance with DHH contractual or regulatory requirements, and/or nationally-recognized accreditation standards.

Aetna Better Health will perform a minimum of two (2) DHH approved PIPs in the first Provider Agreement year. During the first Provider Agreement year we will implement the DHH required PIP listed in Section 1 of Appendix DD - Performance Improvement Projects and will choose the second PIP from Section 2 of Appendix DD. We will conduct all PIPs required by DHH. Within three (3) months of the execution of the Provider Agreement and at the beginning of each Provider Agreement year thereafter, our CMO will submit, in writing, a detailed description of each PIP to DHH for approval. This description will be presented in the form and format prescribed by DHH. At a minimum our PIPs will include the requirements specified in RFP section 14.3.8.4.

In the table below we have documented States where in the past 5 years we have successfully performed improvement initiatives similar to the PIPs DHH identified in Appendix DD. This experience will be critical to the implementation of the DHH PIP process.

DHH PIP Topic	State performed Similar PIP	Outcome	Years
Ambulatory Care Measure – ED Visit category - The number of ED visits per 1000 member months	DE	Significant decrease in ED utilization for members with CHF, $113,051 cost savings.	2008-2009
Cervical CA Screening – The percentage of women 24-64 years old in the denominator that received a cervical CA screening	TX	HEDIS rates meet NCQA 75th percentile at 73%.	2009-ongoing
Breast CA Screening – The percentage of women 40-69 years old that received a breast CA screening	AZ	HEDIS rates for breast cancer screening increased from 58% to 68%.	2003-2007
Well Child Visits in the First 15 Months of Life – The percentage of children in the denominator that received at least 6 well child visits in the first 15 months of life	TX	HEDIS rates meet NCQA 75th percentile at 67%.	2009-ongoing

Aetna Better Health's CMO, with the support of the Quality Management Coordinator and Performance/Quality Improvement Coordinator will manage and direct the selection, design, implementation, and evaluation of each PIP. This workgroup will collaborate with executive and management personnel to make certain that each PIP complies with DHH's requirements, follows federal protocols, and adheres to CMS and NCQA standards. Under the supervision of the MD, the Quality Management Department, led by the Quality Management Coordinator will be responsible for implementing, managing, tracking, and reporting PIP activities.

Under the leadership of the MD, the Quality Management Department will prepare a PIP proposal for review by the QM/UM Committee. This committee will select each PIP topic based on:

a) Objective performance indicators including DHH performance measures,
b) Quality of care concerns including trends from peer review;
c) Member's demographic characteristics and health risks;
d) Prevalence of the chosen topic or condition within our membership;
e) Member and family/caregiver input;
f) Provider input;
g) Input from advocacy organizations or similar community stakeholder
h) Utilization management activities; and

i) Trends identified through network/performance monitoring, results of credentialing/re-credentialing, utilization management outcomes and actuarial analysis (member/provider profiling).

An overriding selection factor will be our ability to achieve significant improvement sustainable over time in clinical care and non-clinical care areas through the selected topic. After selecting a PIP topic, the Aetna Better Health will submit the PIP proposal for review and approval by the Board. It is our standard operating procedure that each PIP is designed to achieve significant improvement, sustainable over time that have positive effects on health outcomes of our members or will improve member or provider satisfaction. Therefore, each PIP will involve the following elements:

- Performance measurement using objective quality indicators;
- Implementation of system interventions to achieve improvement in quality;
- Evaluation of the effectiveness of the interventions; and
- Planning and initiation of activities for increasing or sustaining improvement.

Improving care and services

Aetna Better Health's approach to developing PIP interventions to improve care and services occurs through the QM/UM Committee. The responsibilities of the QM/UM Committee are to: 1) perform root cause analysis and propose evidence-based interventions; 2) cross-functionally discuss the PIP topic, purpose, objectives and timeframes; and 3) determine that the intended PIP outcome is reasonably attributed to the planned interventions. Our process is iterative, multi-departmental, and multi-disciplinary; the exchange of information and ideas during this process is instrumental to the effectiveness of our interventions. This enables each core department to have input into design of the interventions. The CMO will present the proposed PIP topics to the Board for review, amendment and final approval.

Once the PIP proposal is approved, the CMO and the Quality Management Department works collaboratively to identify and implement multi-departmental interventions that will lead to real and sustained improvements in care. In designing our interventions, we benchmark our internal data to other comparable state Medicaid programs that have submitted HEDIS data to NCQA and are at or above the 75th percentile. We then conduct literature research to identify and evaluate best practices and talk to other Medicaid programs and agencies who have successfully implemented interventions to address similar issues. The CMO and Quality Management Coordinator will discuss the results of these analyses at our QM/UM Committee and Service Improvement Committee meetings, soliciting committee members' input as to the most effective solutions to implement, including the use of relevant clinical practice guidelines. Based upon the results and trending identified, the committees will collaborate with Aetna Better Health personnel, including the Aetna Medicaid Business Unit corporate medical management personnel, Information Technology (IT), Informatics, and Actuarial Services, to develop and implement processes and programs to improve member health outcomes, quality of care, and services. The resulting intervention strategy plan for improving performance will be submitted for review and approval by the Board.

Evaluating the Effectiveness of Interventions

Aetna Better Health performs systematic, consistent, ongoing collection and analysis of, accurate, valid, and reliable data to evaluate the effectiveness of interventions. Our state-of-the-art information technology system will provide the data collection, storage, integration, validation and retrieval resources, and support for identifying, selecting, tracking, and analyzing data/information to facilitate our PIP development, study and evaluation efforts. In utilizing the PDSA model, Aetna Better Health establishes baseline measures using performance measures, study indicators, and targeted benchmarks. To assess the overall effectiveness of interventions, we will compare the results of re-measurement periods to the initial baseline measurement results and our targeted benchmarks. We then determine if:

1) If there is quantitative, measurable and sustained improvement in processes or outcomes of care according to the predetermined PIP study indicators,
2) If the improvement in performance is a result of the planned interventions or to some unrelated occurrence, and
3) If there is any statistical evidence that the improvement reflects true improvement.

When Aetna Better Health presents the statistical results to the Board, DHH, or to our providers it is our standard operating procedure to fully disclose the study's purpose, methodology, and outcomes, including the statistical significance of the results. To demonstrate quantifiable evidence of improved quality of care or services, we measure improvement according to benchmarks established by DHH or QMOC (for internally selected PIPs) and approved by the Board.

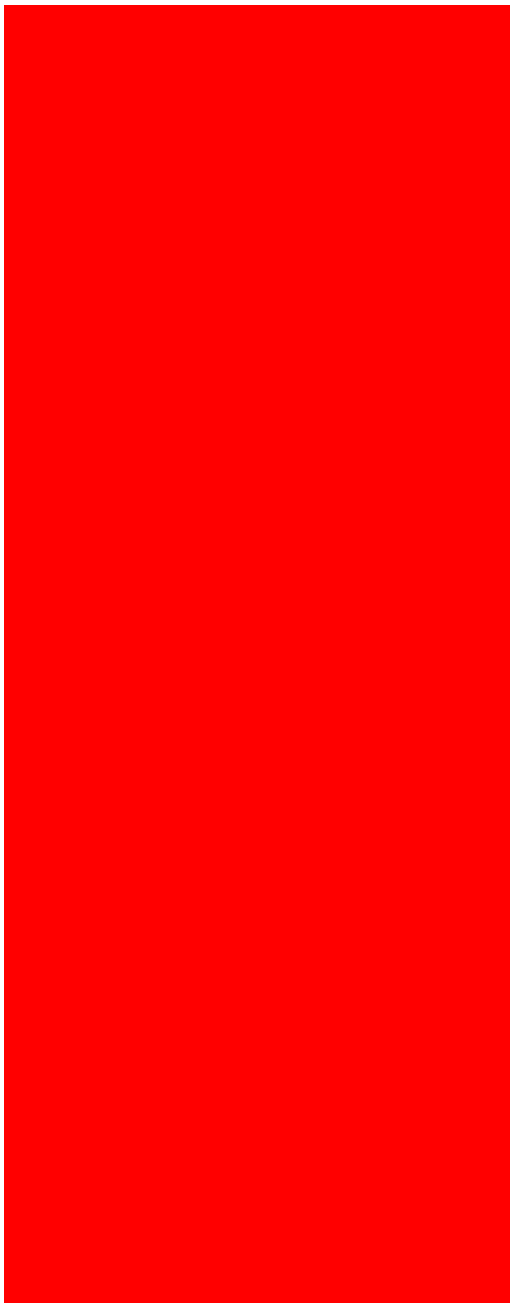
Aetna Better Health determines the effectiveness of interventions by measuring statistically significant changes in performance according to predefined quality indicators. If our continuous measurement and data analysis indicates that our interventions were unsuccessful, we report our findings to QMOC, the Board, to DHH and to providers. The QM/UM Committee will review this information and take action based upon the results of the interventions, and determine to continue existing interventions, modify any interventions, or discontinue ineffective interventions. QMOC will report its findings to the Board. The Board provides direction on additional enhancements to improve the effectiveness of interventions. This cycle will continue until real and sustained improvement is achieved. If our continuous measurement and data analysis indicates that our interventions were successful, we incorporate these interventions into our ongoing quality management processes.

Aetna Better Health utilizes the PDSA model to document the results of our QAPI program. The QM Department conducts continuous data analysis to determine if current performance represents a statistically significant improvement, and if the improvement can be reasonably associated to the interventions. Each of our quality improvement studies or activities has one or more quality indicators we use to track, analyze, and report improvement and performance during the life cycle of the activity. We determine the effectiveness of interventions based on the statistical significance of improvements to objective, clearly defined and relevant indicators.

Aetna Better Health uses the results of its monitoring and evaluation of overall performance to assess our QAPI program. As part of our assessment process, we distribute results of the PIP and

QAPI program outcomes to internal personnel and our network. Our ongoing monitoring and evaluation process includes an annual assessment of the efficacy of each member and provider intervention(s). We use these results to develop our work plan for the subsequent measurement year, which forms the basis for the QAPI program activities for the next year. This allows us to base improvements to our QAPI structure on the effectiveness and success of implemented, evidence-based interventions.

88 J.4



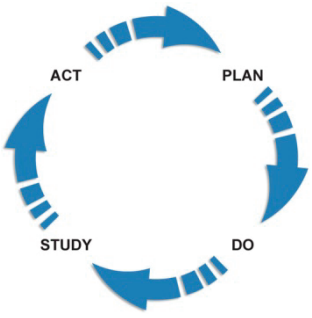
J.4 Provide a description of focus studies performed, quality improvement projects, and any improvements you have implemented and their outcomes. Such outcomes should include cost savings realized, process efficiencies, and improvements to member health status. Such descriptions should address such activities since 2001 and how issues and root causes were identified, and what was changed.

Aetna Better Health's Quality Assessment Performance Improvement (QAPI) program, under the leadership of our Chief Medical Officer (CMO) is a continuous quality improvement process that includes comprehensive quality assessment and performance improvement activities involving the health plan's clinical and operational leaders. Through this systematic and organized process we continuously examine our programs and processes to identify opportunities for continued improvement. The foundation of our QAPI program is our Quality Assessment/Performance Improvement Plan (QAPI Plan) that provides the administrative and functional framework for our quality and performance improvement activities for:

- Identifying and selecting Performance Improvement Project (PIP) topics
- Inter-department communication, cooperation, and coordination
- Evaluating effectiveness of our interventions; and
- Guiding our processes for assessing clinical and non-clinical processes.

Our QAPI processes are member-centered and supportive of members and the members' families/caregivers in achieving and/or maintaining positive health outcomes.

Aetna Better Health uses the Plan-Do-Study-Act (PDSA) model to assess our processes for tracking, trending, analyzing, and acting upon performance measure, and surveillance data. Our PDSA approach involves leadership from Aetna Better Health's entire organization. The PDSA model for continuous improvement provides the framework for our approach to developing and implementing interventions through the following steps:



1. Plan. Recognize an opportunity and plan a change.
2. Do. Test the change. Carry out a small-scale study.
3. Study. Review the test, analyze the results and identify what we've learned.
4. Act. Take action based on what you learned in the study step: If the change did not work, go through the cycle again with a different plan. We will incorporate successful interventions into ongoing systems, and use what we learned to plan new improvements, beginning the cycle again.

The leadership from Aetna Better Health's entire organization participates in the PDSA process. Our Board of Directors (the Board) is ultimately responsible for all aspects of our medical management program. This responsibility includes the evaluation and oversight of the efficiency, effectiveness and outcomes of the QAPI program. The Board provides strategic management direction to our QAPI program and evaluates the degree that the philosophy and

scope of the QAPI program is incorporated within each operational/management unit and across Aetna Better Health's operations. The Board delegates authority to Aetna Better Health's Chief Executive Officer (CEO) to develop and administer the medical management program (including quality management). The CEO delegates authority and responsibility to our Chief Medical Officer (CMO) to execute all aspects of our medical management program. The CMO has responsibility, accountability, and authority for directing the development and implementation of the QAPI program. Our QAPI program receives feedback from our members and providers to continuously improve our programs, operations, and management approach. These program, operational, and management improvements lead to enhanced member health outcomes and efficiency of provider services. Our CMO has the support of our Aetna Medicaid Business Unit corporate Utilization Management (prior authorization, concurrent review, retrospective review), Case Management, Informatics, Information Technology (IT), Actuarial Services, and Claims personnel to continually strengthen and improve our ability to develop, implement, monitor/evaluate, and replicate successful interventions to improve health outcomes and quality of care. We consider the collection of accurate, timely, and complete quality management data and results of clinical performance measures to be pivotal to developing successful interventions to improve health outcomes and quality of care.

Aetna Better Health gathers, analyzes, evaluates/monitors, and reports utilization data to effectively manage and deliver medically necessary and covered services in the amount, intensity, and duration necessary to achieve improved health outcomes for our members across the continuum of care (from prevention to the end of life). Our goal is that the members receive the right service, at the right time, and at the right level of care/setting. We consider the collection of accurate, timely, and complete utilization data to be pivotal to our success to facilitate the delivery of appropriate care and services to our members. One of our major sources of utilization data is claims and encounters data. These data are our most significant source of information for the evaluation/monitoring and reporting of utilization patterns.

We augment claims data with prior authorization (PA) information, from both our PA Department and information from Integrated Care Management (ICM). Both the claims data and encounters are treated the same by our Actuarial Services Data Base (ASDB) - our claims warehouse. ASDB supports our reporting and analytical needs, such as our multidimensional predictive modeling and statistical outlier analysis. ASDB includes eligibility, provider, prior authorization, pharmacy, and claims data and serves as a key data source for medical management. Analysts from our Informatics Department use the proprietary Actuarial Analytics Web Portal (AAWeb), an interactive interface, as a point-and-click query tool to access reports; drill down into data and export information from ASDB. For instance, AAWeb can generate customized analyses to identify favorable and unfavorable cost and utilization trends, measure performance against key benchmarks, and provide summary information. It is a powerful tool that supports our QAPI program and provides our leadership with access to member/provider cost and utilization trends that are used in identifying potential PIP topics.

Aetna Better Health's CMO, with the support of the Quality Management Coordinator and Performance Improvement Coordinator manages and directs the selection, design, implementation, and evaluation of each PIP. This workgroup collaborates with executive and management personnel to make certain that each PIP complies with state requirements, follows

federal protocols, and adheres to CMS and NCQA standards. Under the supervision of the CMO, the Quality Management Department, led by the Quality Management Coordinator is responsible for implementing, managing, tracking, and reporting PIP activities. Under the leadership of the CMO, the Quality Management Department prepares a PIP proposal for review by the QM/UM Committee. This committee selects each PIP topic based on:

1) Objective performance indicators including Department of Health and Hospitals (DHH) performance measures
2) Quality of care concerns including trends from peer review
3) Member's demographic characteristics and health risks
4) Prevalence of the chosen topic or condition within our membership
5) Member and care giver input
6) Provider input
7) Input from advocacy organizations or similar community stakeholder
8) Utilization management activities; and
9) Trends identified through network/performance monitoring, results of credentialing/re-credentialing, utilization management outcomes and actuarial analysis (member/provider profiling)

Topic areas that address improved care for high risk members and appropriate utilization of high volume services receive priority in selection of QAPI activities. An overriding selection factor is our ability to achieve significant improvement sustainable over time in clinical care and non-clinical care areas through the selected topic. After selecting a PIP topic, the QM/UM Committee will submit the PIP proposal for review and approval by the Board. It is our standard operating procedure that each PIP is designed to achieve significant improvement, sustainable over time that have positive effects on health outcomes of our members or will improve member or provider satisfaction. Therefore, each PIP involves the following elements:

- Performance measurement using objective quality indicators;
- Implementation of system interventions to achieve improvement in quality;
- Evaluation of the effectiveness of the interventions; and
- Planning and initiation of activities for increasing or sustaining improvement

Aetna Better Health's approach to developing PIP interventions to improve care and services occurs through the QM/UM Committee whose membership includes representatives from our Managerial, Operational, Information Technology, Quality, and Utilization personnel. The responsibilities of the QM/UM Committee are to: 1) direct and review Quality Improvement (QI) activities; 2) review data and propose evidence-based interventions; 3) designate evaluation and study design procedures; 4) identify task forces/committees to review areas of concern in the provision of healthcare services to members; 5) analyze periodic members' service utilization patterns; 6) share results and information on the QAPI program cross-functionally throughout the Plan; and7) determine that the intended PIP outcome is reasonably attributed to the planned interventions. Our process is iterative, multi-departmental, and multi-disciplinary; the exchange

of information and ideas during this process is instrumental to the effectiveness of our interventions. This enables each core department to have input into design of the interventions. The QM/UM Committee reports its findings and recommendations to the QMOC. The CMO will present the proposed PIP topics to the Board for review, amendment and final approval.

Aetna Better Health uses the PDSA approach as our process for evaluating the effectiveness of interventions. Our state-of-the-art information technology system will provide the data collection, storage, integration, validation and retrieval resources, and support for identifying, selecting, tracking, and analyzing data/information to facilitate our study and evaluation efforts. The QM Department applies the PDSA model to conduct continuous data analysis to determine if improved performance represents a statistically significant improvement, and if the improvement can be reasonably associated to the interventions. Each of our quality improvement studies or activities has one or more quality indicators we use to track, analyze, and report improvement and performance during the life cycle of the activity. We determine the effectiveness of interventions based on the statistical significance of improvements to objective, clearly defined and relevant indicators.

Aetna Better Health uses the results of its monitoring and evaluation activities to assess our QAPI program. As part of our assessment process, we distribute results of the PIP and QAPI program outcomes to internal personnel, our network and advocacy groups. Our ongoing monitoring and evaluation process includes an annual assessment of the efficacy of each member and provider intervention(s). We apply these results to develop our work plan for the subsequent measurement year, which forms the basis for the QAPI program activities for the next year. This allows us to base improvements to our QAPI structure on the effectiveness and success of implemented, evidence-based interventions.

Aetna Better Health has a strong history of effectively using our QAPI structure and processes to develop focus studies, improvement projects, and process improvements that result in improved member health outcomes, system enhancements, and cost savings. We have multiple examples of QAPI improvement strategies that demonstrate our commitment to improving quality of care and performance throughout our organization. These interventions clearly illustrate our capacity and capability to achieve measurable and sustained improvement in delivery of health care services. We have successfully applied this structure to identify and implement performance improvement projects that have resulted in improved health outcomes for our members, as described below.

Examples of Quality Improvement Projects

Aetna Better Health supports the Louisiana Medicaid program's goals to improve health outcomes for its members, reduce costs, and improve care coordination. As demonstrated in the examples described below, we have successfully implemented initiatives that address the challenges currently faced by this state – low rates of children accessing preventive care, poor health outcomes due to a lack of prenatal care, and high costs associated with avoidable hospital admissions for members with ambulatory care sensitive conditions (e.g. asthma, diabetes). Aetna Better Health has addressed these same issues in other states through initiation of improvement activities developed through its quality management processes and structure. As demonstrated in the following examples, our integrated, data-driven QAPI program allows us to identify opportunities for improvement, target initiatives, and yield positive results in health

outcomes, cost savings, and process improvements. These examples highlight improvements made for populations similar to those we will serve in Louisiana. We will build on our experience and the excellence of our existing programs when designing programs to monitor services and quality to assure our Medicaid members in Louisiana receive effective, efficient, high quality services.

- Example 1 – Access to Early Periodic Screening and Testing (EPSDT) services
- Example 2 – Improved Prenatal Care for High Risk Pregnant Members
- Example 3 – Reducing Inappropriate Emergency Department and Hospital Admissions

For each PIP, the detailed description includes the PIP's focus, reason for selection, barriers, interventions used, and improvements achieved.

Example One – EPSDT

Aetna Better Health has an established history of providing ready access to preventive care and services, especially for members under 21. It is our experience that these services can prevent significant health problems and positively affect early social and academic achievement. To this end, we collaborate closely with caregivers, Primary Care Providers (PCPs), community organizations, schools, school districts and other stakeholders to promote an awareness of the importance and availability of well child services and screenings. As demonstrated below, our initiatives have resulted in sustained improvements in the rates of children accessing EPSDT services, thus improving health outcomes and reducing costs.

Issue Identification: Although the benefits of connecting children to preventive care are well-documented and include, among other things, improvements in overall health status and reduced health care costs, a recent study by the U.S. Department of Health and Human Services found that fewer than 50 percent of children in the study sample received any documented EPSDT services. As a result, increased access to EPSDT services is a national priority for Medicaid programs.

To evaluate our performance in providing EPSDT services to members, Aetna Better Health routinely calculates and reviews HEDIS®[3] metrics. We then benchmark our results against state and standards and NCQA percentiles. This information is presented to our Quality Management/Utilization Management (QM/UM) Committee for review and identification of performance improvement opportunities. Through this process, we identified an opportunity to improve the rates of children receiving EPSDT services.

Due to the large number of children served in our programs nationwide and the importance of EPSDT services, Aetna Better Health developed a performance improvement project (PIP) across all of our plans. While the PIP topic and framework is consistent for all of our Aetna Better Health affiliated plans, each plan designed interventions that specifically addressed the unique needs of their populations.

Root Cause Analysis. The focus of this PIP was to improve access to EPSDT services for targeted members by systematically identifying and addressing barriers to care. Therefore,

[3] HEDIS® is a registered trademark of the National Committee for Quality Assurance.

understanding barriers to access is essential to seeing that members receive appropriate services, including regular preventive services.

Aetna Better Health trains our member services, care management, grievance and appeals, provider services, quality management, and utilization management (prior authorization, concurrent review, retrospective review) personnel to identify potential obstacles to care during member communications opportunities and to work with caregivers, PCPs and other relevant entities to address them. We find that, although most caregivers understand the importance of preventive care, many confront seemingly insurmountable barriers to readily comply with preventive care guidelines. Examples of barriers to preventive care that we have encountered include:

- Cultural or linguistic issues
- Health literacy issues
- Lack of perceived need if children are not sick
- Lack of understanding of the benefits of preventive services
- Competing health-related issues or other family/work priorities
- Transportation
- Scheduling or other access issues
- Child care
- Adolescent resistance to obtaining "pediatric" care and willingness to participate
- Coordinating care for services delivered by "carved out" vendors

Aetna Better Health also trains its member services and care management personnel to identify potential obstacles to care during member communications opportunities and to work with family members/caregivers, PCPs and other relevant entities to provide access to services. We track and trend this information for report to the QM/UM Committee for review and recommendations on interventions for systems improvements that lead to positive health outcomes.

Improvements

Aetna Better Health considers the member's Primary Care Physician (PCP) to be the patient-centered medical home for EPSDT members. To that end, we focus our interventions on promoting relationships between members, families, and their PCPs. These initiatives focused on 1) member and provider education, 2) member outreach, 2) partnering with local community organizations, 4) offering member incentives, and 5) removing real and perceived barriers to care. Aetna Better Health's policies and procedures for early and periodic screening, diagnosis and treatment (EPSDT) provide the framework for our interventions and facilitate member access to and receipt of EPSDT services. We require our network PCPs to provide all EPSDT services in compliance with federal and state regulations and periodicity schedules. To accomplish this, we also closely monitor EPSDT metrics throughout the year to identify trends and potential opportunities for improvement.

Our overall strategies for improving EPSDT services are described below, as are Plan-specific strategies for Texas and Missouri, both of which resulted in substantial improvements in access to preventive care for our members.

Member Strategies

Aetna Better Health takes several approaches and strategies in an effort to reach and educate our members and their caregivers about the importance and value of preventive services, including EPSDT services. Our approaches and strategies include, but are not limited to, the following:

- New Member Welcome Packets and Welcome Calls provide information regarding our services and offer members with assistance in accessing EPSDT related services
- Member Handbooks, newsletters and on-hold messages
- Member outreach and education (including mailings, reminder cards for appointments due and missed appointments, and telephone calls)
- Researching returned member mailings in an effort to identify accurate contact information
- Contacting PCPs for assistance in locating members
- Coordinating with state and community organizations, including prenatal clinics and other prenatal care providers, to educate pregnant women and encourage EPSDT visits for infants
- Member incentive and rewards programs
- Including EPSDT standards in provider contracts
- Provider Manuals and newsletters
- Provider outreach and education, including on-site training at provider offices
- Provider Preventive Care Toolkit/CD, with preventive care information, resources and forms
- Eligibility look-up reminders (i.e., when providers check for member eligibility status, they are reminded of any EPSDT encounters or screens due for members)
- Provider patient rosters of children due for a well-child appointment
- Provider letters containing information about HEDIS measures, screening, documentation and billing requirements
- Health Plan Web sites
- Community outreach initiatives, including, but not limited to:
  - Back-to-school fairs
  - Local health fairs
  - Swim parties
  - On-site visits to schools
  - Collaboration with community-based organizations

Aetna Better Health uses alternative means of communication for our members whose learning styles are better served through visual or oral presentation approaches. We also offer our preventive educational materials and Member Handbook in alternative languages to meet the needs of our members who are more comfortable with materials in another language. To further address the needs of our members, we provide our personnel with annual cultural competency

training and work with our providers to better understand differing cultural beliefs involving health and health care delivery

Aetna Better Health affiliated plans in other states have implemented initiatives to target any child who has not yet received a well care visit in the last 12 months as a priority for follow up. Through these programs, the health plans created an "interventions database" that included children with missing services and contact information for the member and the provider. In addition, provider level HEDIS rates were calculated at the group level for the previous twelve month period to identify which members have gaps in care. These data were used to develop provider incentive strategies to increase screening and participation rates.

Provider Strategies

Given the important role PCPs can play in educating their patients about EPSDT services Aetna Better Health has implemented a number of strategies targeted to our provider network.

We have developed provider educational and outreach activities designed to emphasize the importance of EPSDT screenings and services and to help our providers more readily identify patients overdue for services, document preventive services and to identify and resolve other issues that impede provider participation – including reimbursement. We work with the provider community to increase compliance with EPSDT screening and treatment standards through the following strategies:

- Creating an EPSDT toolkit that makes it easy for providers to comply with EPSDT visit documentation requirements
- Providing online training modules and access to educational Web sites
- Increasing reimbursement for preventive care services
- Linking pay for performance criteria to preventive service delivery rate
- Implementing initiatives to increase well-child and dental visits
- Promoting clinical practice guidelines specific for EPSDT
- Developing member profiling and provider report cards that target EPSDT services
- Conducting on-site visits with providers to identify barriers to care
- Conducting an annual audit using HEDIS criteria and American Academy of Pediatrics screening standards to improve compliance with EPSDT benchmarks
- Implementing Performance Improvement Plans that include EPSDT, if needed
- Producing periodic reports for PCPs identifying those members who are in need of EPSDT services.

Aetna Better Health works collaboratively with providers to stress the importance of EPSDT screenings and services and closely monitors compliance with established benchmarks. We inform providers about the EPSDT program through the following mechanisms:

- Provider Contracts
- Provider Manual (updated and distributed annually)
- Eligibility look-up reminders through our AboveHealth® secure Web portal (i.e., when providers check for member eligibility status, they are reminded of any due member screens)

- Provider bulletins
- Aetna Better Health's Web site
- On-site provider meetings
- Provider Newsletters
- Individual provider profiles
- Provider incentive programs

Outreach Strategies

Aetna Better Health understands the importance of mailing educational materials and reminders to members and providers, but also believes that additional steps are necessary to meet the overall goal of increasing EPSDT participation rates. These include:

- Targeted outreach calls
- Researching returned mailings in an effort to identify accurate contact information
- Contacting PCPs for assistance in locating members
- Coordinating with state and community organizations, including pre-natal clinics and other pre-natal care providers, to educate pregnant women and encourage EPSDT screenings and services for infants
- Coordinating with schools and attending health fairs and other community events

Aetna Better Health's Case Managers are responsible for coordinating and tracking EPSDT services, including services for children with special health care needs who are enrolled in the case management program. Our Case Managers use a variety of care management tools (e.g., CORE, Aetna Better Health's proprietary predictive modeling application) and assessments to identify members in need of coordination of care and schedule targeted outreach calls. They enter information gathered from these activities into our web-based care management business application (Dynamo™), to enable Case Managers to review a member's encounter history, schedule needed appointments and plan follow up activities.

In addition to outreach to members participating in our case management program, Aetna Better Health affiliated plans have successfully implemented the following outreach activities:

- For members under age six, an EPSDT Coordinator follows-up these mailings with outreach calls to remind members about the importance of well-child visits.
- Making outreach calls to parents and guardians of members who are nine months of age if the tracking record shows that the infant had three or fewer well-child visits. The EPSDT Coordinator or Care Manager encourages the parent or guardian to schedule an EPSDT visit and can initiate a three-way call with the PCP's office to arrange for an appointment.
- Making outreach calls to parents and guardians of 12 and 18 month old members to encourage a well-child visit and encourage immunizations that meet the periodicity schedule.
- Prompting an automated call to members who have not received EPSDT services within the recommended timeframes.
- Attempting to make telephone contact with the member's parent or guardian.

Aetna Better Health affiliated plans have also developed processes for.

- Contacting a member's PCP every six months to inquire whether an EPSDT visit occurred and, if not, request that the PCP reach out to the parent/guardian to schedule an appointment.
- Utilizing our case management tracking systems to identify children between nine months and six years of age to confirm the completion of blood lead testing and identify any children with elevated lead levels for appropriate follow-up treatment.

Partnerships with External Entities

Aetna Better Health understands that high quality care includes the establishment of a medical home with a PCP. However, in areas where access issues impede preventive care, we seek partnerships with a broad array of additional supports, including schools, FQHCs and RHCs, Head Start, day care centers, churches and other appropriate entities to enhance our members' access to preventive services. Consistent with our emphasis on a medical home, we tie reimbursement of these alternative providers to sharing documentation of the visit and any diagnostic outcomes with Aetna Better Health and the member's PCP. Some specific examples include:

Partnership with WIC

Aetna Better Health has successfully partnered with the Women, Infant, and Children (WIC) program in other states to identify children who are overdue for a well-child visit and generate a colorful flyer to place in the members' files at the county WIC office. When the member next visits the WIC office, the nutritionist passes out the flyer and provides counseling on the importance of preventive health screenings and immunizations. In addition, the WIC office may notify us of the visit so that our personnel can conduct follow-up and assist with scheduling an appointment and arranging for transportation, if needed. We found that members enrolled in WIC are more likely to receive needed screenings and services than those who are not.

Partnership with School Nurses

Aetna Better Health has a significant history of partnering with school nurses and other school personnel regarding child health issues and preventive services (e.g., immunizations, EPSDT, asthma management, etc.) For example, our Missouri health plan partnered with a local school district to provide EPSDT services during a "back to school" fair. In addition, our outreach personnel arranged to visit schools to give presentations on various health education topics and provide school nurses with additional health education resources. Aetna Better Health also coordinates with schools to provide medically necessary supportive services as identified in the child's Individual Education Plan (IEP) or Individual Family Service Plan (IFSP).

Additional Partnership Examples

In addition to the collaborative activities described above, Aetna Better Health has:

- Partnered with primary care clinics to schedule well child appointments for preschool aged children. Our staff contacts the parents and guardians of the children and then initiates a contact with the clinic.
- Partnered with other managed health care plans on statewide adolescent well care performance improvement projects
- Partnered with the Department of Children and Families (e.g., child abuse, enlisting foster families to schedule well child visits and immunizations, etc.)

- Collaborated with local civic organizations to disseminate information regarding our well child programs

Member Incentives

Aetna Better Health offers incentives to members that reinforce the importance of EPSDT screenings and services. The incentives comply with state and federal limitations. They may include a gift card redeemable at a local grocery or discount store, or a prepaid telephone card, MP3 downloads or other member reward. We offer these rewards after the member keeps screening appointments or receives identified EPSDT services at the appropriate time.

Integration into Case Management Programs

Children may also be referred and integrated into our Case Management Program for further assistance in accessing health care services to meet their needs. Aetna Better Health's case managers are responsible for coordinating and tracking EPSDT services, including services for children with special health care needs. Case managers complete assessments for members less than 21 years of age to identify needed EPSDT visits and incorporate these services into the member's care plan. Our Case Managers use a variety of care management tools (e.g., CORE™, our proprietary predictive modeling application) and assessments to identify members in need of coordination of care and schedule targeted outreach calls. They enter information gathered from these discussions into our web-based care management business application system (Dynamo™), to enable Case Managers to review a member's encounter history, schedule needed appointments and plan follow up activities.

Methods to Monitor and Increase EPSDT Screening Standards

Outreach and education are critical first steps toward increasing screenings and participation, but it is equally important to monitor progress toward targeted objectives and, if necessary, to develop and implement corrective actions. Aetna Better Health identifies all eligible children, including foster care children, children with developmental disabilities, behavioral health conditions and other special health care needs, and collects and tracks data to monitor the levels of screening and participation. We incorporate the American Academy of Pediatrics screening benchmarks into the monitoring process and share this information with members, providers, vendors, the State and other appropriate entities.

Aetna Better Health requires providers who deliver well child services to track these services and:

- Document each assessment on the appropriate tracking form and verify that the record is complete and readable
- Comply with the health plan's periodic review of standards, including chart reviews
- Comply with Minimum Medical Record Standards for Quality Management and EPSDT Guidelines and any other requirements
- Report all encounters on the claims submission form by recording the CPT preventive codes

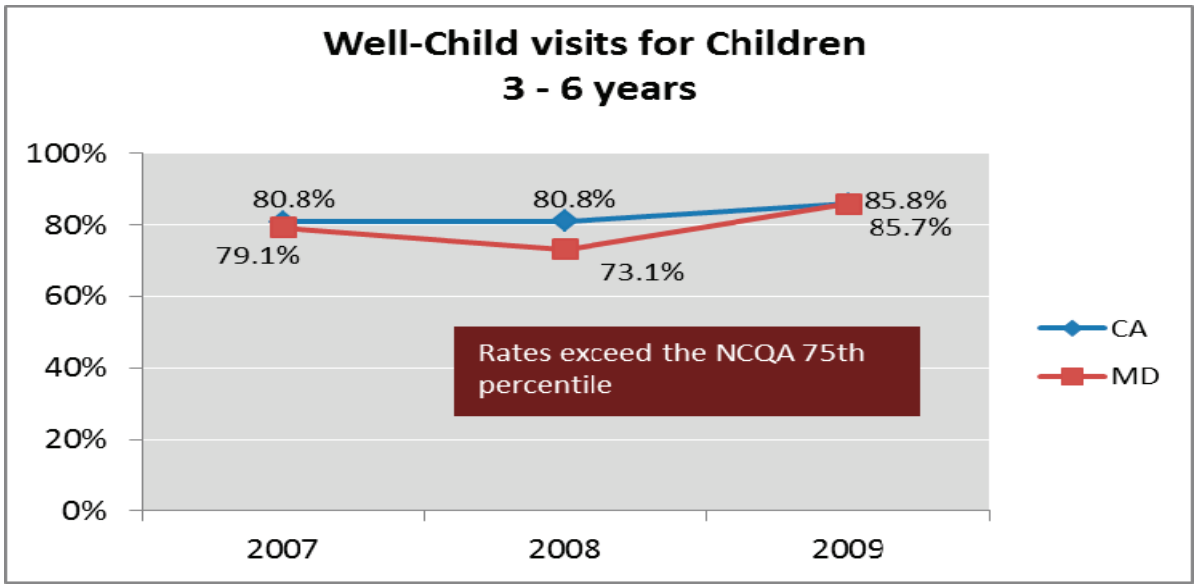
Aetna Better Health conducts regularly scheduled medical record reviews to see that PCPs' medical records document all screenings and services provided to members and to verify compliance with established regulatory standards. During this review, we verify compliance with EPSDT required screenings in such areas as:

- Appropriate immunizations according to age
- Blood lead testing
- Hearing/vision screening
- Developmental assessment
- Growth screening
- Dental screening/referral
- Anticipatory guidance

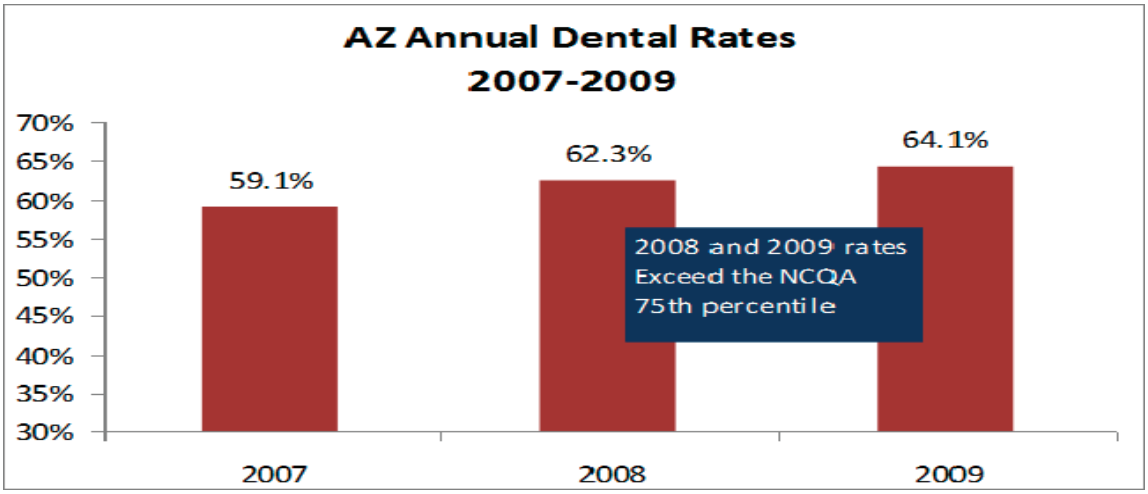
If provider records have missing information, Aetna Better Health educates providers on EPSDT requirements. Continual failure on the part of the provider to adequately maintain medical records can result in the provider developing a corrective action plan; ongoing and consistent follow-up with the provider to track improvement; sanctioning the provider by capping enrollment or taking other actions; including termination of the provider's contract.

Outcomes

As a result of our extensive outreach activities, Aetna Better Health's annual HEDIS rates for dental visits and well care visits for all age groups compare favorably to national benchmarks, in many cases exceeding the national 75th percentile rate. Our Maryland Medicaid and California CHIP health plans have demonstrated statistically significant improvement in Well Child Visits (3 – 6 Years), with calendar year 2009 (HEDIS 2010) rates exceeding the NCQA 90th percentile rate benchmark. As demonstrated in the graphs below, Aetna Better Heath's affiliates consistently perform well on HEDIS measures related to EPSDT services including well child visits and dental care.



As shown in the graph below, our initiatives to increase EPSDT members' access to dental care has resulted in our Arizona plan far exceeding the national benchmark for annual dental visits for children aged 2 – 21 years old.



Cost Savings

While cost saving have not been calculated as an outcome for this performance improvement project, they can be implied. Research shows that children with incomplete well-child care in the first 6 months of life are significantly more likely than children with complete care to visit an Emergency Department for an upper respiratory tract infection, gastroenteritis, or asthma. In fact, children with incomplete care are 60% more likely to visit an Emergency Department for any cause compared to children who are up-to-date on their well-child care. In simply comparing the costs of emergency room and hospitalization rates to preventive care costs, it is clear that improving access to EPSDT services results in cost savings for the Medicaid program as well as improved member health outcomes[4].

Example Two – High Risk Pregnant Members

The health of mothers and infants is vitally important to our nation, both as a reflection of a large portion of our population and as an indicator of the health status of the next generation. Pregnancy is one of the primary categories for Medicaid eligibility and deliveries account for almost 50 percent of Medicaid inpatient discharges. Although Medicaid has increased access to medical care for low-income pregnant women, this population remains at high risk for poor pregnancy outcomes as these members often begin prenatal care later and have fewer visits. In our experience, Medicaid members are far less likely than commercial or Medicare members to have stable housing, a reliable mailing address, a telephone, or a long-term relationship with a health care provider making care coordination and support critical for this population. Due to the potential for negative health outcomes in this population, assuring that pregnant women on Medicaid receive proper prenatal care is a priority for Aetna Better Health. To that end, we have implemented a series of improvement initiatives designed to increase access to care for pregnant women, thus improving their overall health as well as the health of their babies. Additionally, we have highlighted some initiatives implemented by our Texas and Missouri Care plans which serve a large population of pregnant women.

[4] Reference: Hakim RB, Ronsaville DS. Effect of compliance with health supervision guidelines among U.S. infants on emergency department visits. Arch Pediatric Adolescent Med. 2002;156:1015-1020.)

Issue Identification

Due to the potential for poor birth outcomes related to inadequate prenatal care, including low birth weight, and infant mortality, Aetna Better Health has determined that improving access to prenatal care is a priority. To assess our performance in facilitating access to prenatal care for pregnant women, we routinely monitor HEDIS rates for prenatal and post-partum care through our QAPI program, across all affiliated health plans. Additionally, we routinely review member utilization data to detect under and over utilization of services at the member and provider level. We use this information to identify members in need of additional supports or the need to make systemic improvements to the service delivery system. We benchmark these data against state standards, NCQA percentiles, and across health plans to determine opportunities for improvement and present this information to the QM/UM Committee for review and recommendation. Through this process, we identified the need to implement a health plan wide comprehensive perinatal case management program to support our pregnant members.

Root Cause Analysis

In applying the PDSA model for performance improvement, our affiliated health plans conducted root cause analyses for each of their service areas and determined the barriers described below to be factors in members accessing prenatal care. We were then able to target interventions strategies to address each of the identified barriers. Some of the most common barriers identified to members accessing prenatal care include:

- Access to transportation to attend appointments
- Competing needs for members, such as work schedules, child care
- Having high risk conditions
- Substance abuse issues
- Low health literacy
- Lack of provider adherence to clinical practice guidelines

Aetna Better Health also trains its member services and care management personnel to identify potential obstacles to care during member communications opportunities and to work with family members/caregivers, PCPs and other relevant entities to provide access to services. We track and trend this information for report to the QMUM Committee for review and recommendations on interventions to improve access to prenatal care for pregnant women.

Improvements

Aetna Better Health understands that an expectant mother who receives prenatal care is 75 percent more likely to deliver a healthy baby. For this reason, we strive to identify and establish relationships with expectant mothers as soon as possible. To improve prenatal care, Aetna Better Health has developed a comprehensive perinatal and postpartum care program to identify, track and coordinate the care of pregnant members, with a focus on attaining positive health outcomes for both the mother and her newborn. Our Perinatal and Postpartum Case Management Program provides case management to all pregnant members from their date of enrollment (new member) or pregnancy confirmation (existing members) through the 60-day postpartum period. Our overall goal is to assure that these individuals have access to high quality, cost effective prenatal care and timely identification and intervention for postpartum concerns.

Through its perinatal case management program, Aetna Better Health provides support services to enable high risk pregnant women to receive quality prenatal care and achieve a healthy birth outcome. These services have revealed the benefits to early identification and tracking to intervene with those at highest risk for chronic conditions, such as, diabetes, substance abuse, nutritional deficiencies, domestic violence, mental health concerns, and other perinatal and pediatric risks.

Case Management for High-Risk Members

Aetna Better Health's Perinatal and Postpartum Case Management Program is designed to assess for high risk maternal and fetal issues and coordinate and manage the care of women with high risk pregnancies. We recognize that each member's pregnancy is a unique experience and many behavioral, social and medical factors can result in a high risk pregnancy. Aetna Better Health has established a comprehensive perinatal and postpartum care program to identify, track and coordinate the care of pregnant members, with a focus on attaining positive health outcomes for both the mother and her newborn.

Identification of Members

Aetna Better Health understands that early identification is the first step toward improving birth outcomes. Early identification and case management intervention are critical to our program.

Strategies we use to identify and refer pregnant members for perinatal case management include, but are not limited to, the following:

- All plan personnel understand and are educated about our high risk perinatal case management program. Any contact with plan personnel can generate a referral.
- Member services representatives are a frequent first contact point. They refer members who believe they are pregnant or who have questions about maternity-related services.
- Concurrent review/prior authorization personnel refer members who are or may be pregnant when they identify them in an inpatient setting or through pregnancy-related prior authorization requests.
- PCPs are required to refer members who are or may be pregnant.
- Fetal medicine/perinatologists refer pregnant women who are enrolled in our health plan.
- The member handbook and our Web site encourage pregnant members to self-refer. They may use the toll-free number or our Web site to contact the plan.
- Review of internal reports, such as Emergency Department utilization reports, to identify pregnant members accessing services through the ED.

Once the pregnant member is identified for case management services, Aetna Better Health's perinatal case managers work closely with all high risk members to develop a customized care plan that includes: 1) supporting the authorization of, and monitoring adherence care plans of pregnant women; 2) assessing for and resolving barriers; and 3) serving as a center point for communication among all involved parties and identifying community resources to assist members.

Our goal is to improve health outcomes for the mother and her newborn. For high risk pregnant women, we have found the following type of interventions to be most effective in leading to positive health outcomes:

- Assisting members in scheduling and attending prenatal visits. This may include more frequent visits with the OB, tests to monitor the medical problem, blood tests to check the levels of medication, amniocentesis, serial ultrasound examination and fetal monitoring.
- Providing an early referral to high risk OB providers for those women with multiple gestations, severe chronic illness, HIV, substance abuse or other mental health conditions (other than alcohol or domestic violence issues).
- Enrolling members with a history of substance abuse in a treatment program and see that these women go to the "front of the line" for treatment.
- If there is history of prior delivery requiring NICU services, identifying the reason and determining if it is repeatable and/or preventable.
- Providing members who are anemic (a marker for poor nutrition) with iron supplements, conducting an in-depth review of eating habits and diet and provide an early referral to Women, Infants and Children program.

Aetna Better Health's web-based care management business application (Dynamo™) provides perinatal case managers with the ability to track comprehensive information about each member enrolled in our Perinatal and Postpartum Case Management Program. One of our web-based care management business application's (Dynamo™) innovative features is a perinatal risk assessment questionnaire that can identify a member's immediate needs, past and current obstetrical and medical history, and current behavioral or social risks, including substance abuse and domestic violence. The identified risks drive the design of the individualized care plan with interventions specific to each member's needs.

Postpartum Care

Aetna Better Health recognizes that appropriate care for pregnant women continues beyond the delivery through the postpartum period. Timely postpartum care is an essential component of promoting well-being for mothers and babies. The postpartum visit is an opportunity to identify physical and mental health issues, such as postpartum depression, as well as feeding and bonding issues. It is the optimal time for family planning to occur. Our Case Management Program supports this important health step by:

- Follow-up case management: Members enrolled in perinatal case management receive follow-up calls and assessments. These assessments are intended to identify potential maternal physical and mental health issues and assessment basics for the newborn.
- Education: All members enrolled in case management are educated throughout the case management period about the importance of postpartum care.
- Educational Materials: All new mothers receive the "You and Your New Baby Book" which contains helpful information for new moms and stresses the importance of postpartum care.
- Provider Education: Postpartum care is reimbursed under the OB Global Authorization and providers are encouraged to stress the importance of postpartum care to their patients.

Prenatal Appointment Compliance Tool

In addition to the above initiatives, Aetna Better Health collaborates with the Prenatal Appointment Compliance Tool (PACT) program to provide outreach and education to pregnant members. PACT increases utilization of prenatal care by texting identified pregnant members

with educational information and prenatal care reminders from Aetna Better Health's CM/UM/QM and other medical management personnel. Similar to the Text4Baby program, PACT provides valuable information to pregnant members who may not have ready access to health education materials as well as an efficient mechanism for providing member outreach. As a result, pregnant members are more likely to access prenatal care and give birth to health babies.

State Initiatives

Welcome Home Program for Pregnant Women - Texas

In SFY 2009 Aetna Better Health's Texas affiliate, analyzed the hospital readmission rate within 30 days of discharge and determined that 71% of all readmissions were for normal newborns who were admitted for various reasons following discharge from the hospital following a normal pregnancy and delivery. Further analysis showed that only 4% of these infants had a PCP visit within 30 days of birth compared to almost 90% for all other normal newborns. Newborns represent the largest driver of 30 day readmissions in Aetna Better Health's Texas membership.

Based on these two findings Aetna Better Health added a discharge program for newborns and their mothers to the Perinatal case management program called "Welcome Home". Through this program, Case Management Assistants (CMA) attempt to reach every woman who leaves the hospital following a normal delivery within 3 days of discharge. The CMA assists with any special needs the member may have and confirms that the mother has a PCP and has arranged for an appointment for her newborn. The "Welcome Home" program is in its 3rd year of operation.

In order to assess the effectiveness of the Welcome Home program we used claims data to measure the readmission rates for all members and normal newborn PCP visit rates during calendar year 2009, 2010, and Q1 2011.

Outcomes

In response to this initiative, we observed an increase in timely PCP visits for normal newborns in 2009, the first year of the program that was sustained in 2010. We have also observed a steady decline in the readmission rate per 1000 members per year (Table 1).

Table 1. Year 1 and year 2 results for the Aetna Better Health Texas Welcome Home program

Aetna Better Health	2008	2009	2010
Healthy Newborns	4661	6496	6590
Readmission Rate per 1000 members per year	NR	12	9
Savings PMPM	NR	NA	$0.56

Missouri Care Initiatives

One of the largest eligibility categories for our Aetna Better Health affiliated plan in Missouri, Missouri Care is pregnant women. Based on their review of administrative data, the Health plan identified that newborns represented a large portion of hospital admissions. Further analysis of this data revealed that these members had not accessed preventive care through their PCP and that their mothers did not access prenatal care according to established standards. Additionally, the Health Plan noted that its performance on HEDIS measures related to prenatal and post-

partum care could be improved. Therefore, Missouri Care identified access to the full continuum of prenatal and postpartum care for pregnant women to be a priority.

In designing interventions, the Plan conducted a qualitative and quantitative review of data to identify barriers to pregnant women accessing prenatal and postpartum care. Identified barriers included:

- Health literacy
- Pregnant women with untreated substance abuse issues were reticent to access care
- Pregnant women with high risk conditions required assistance in navigating the system

To address these barriers, the Plan then initiated a series of performance improvement activities to improve access to care for pregnant women. The Plan's interventions are described below and include referring members with substance abuse issues to a specialized treatment program, providing home health services for high risk members, and supporting high risk pregnant women with clinical case management services.

Comprehensive Substance Abuse Treatment and Referral (CSTAR)

Missouri Care, an Aetna Better Health affiliated health plan identified barriers to care related to pregnant women with substance abuse issues , The health plan developed a partnership with Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) to refer pregnant women with substance abuse issues for specialized services. Pregnant women may also be referred by their PCP or primary care obstetricians. CSTAR offers clinical services, living arrangements and support services tailored for each member, including screening, assessment, diagnosis and the development of an individual plan of care. CSTAR may also provide recovery and outpatient services in the member's community.

Home health services

To provide care coordination and education to high risk pregnant women, the Health Plan contracted with a home health agency to provide home visits to pregnant members identified as having one or more risk factors for premature delivery. All identified members were offered a minimum of one prenatal and one post-partum home visit. Additional prenatal home visits were authorized based on the results of the home visit assessment. The goal of the prenatal home visit was to increase the member's access to health care services and provide education about pregnancy, nutrition, risks, and the importance of follow-up care. The home health nurse builds a relationship with the member and becomes a source of knowledge and support to the member throughout her pregnancy.

Clinical case management

Missouri Care identified members at high risk of a premature delivery or other complications that might require their baby to be admitted to a Neonatal Intensive Care Unit (NICU) and offered them clinical case management services for the duration of the pregnancy. Case management services included assessment, coordination of care, follow-up on provider appointments, at least one prenatal home health visit as well as other supportive services.

Missouri Care's (Aetna Better Health affiliate) prenatal care program resulted in a 20% reduction in low birth weight babies.

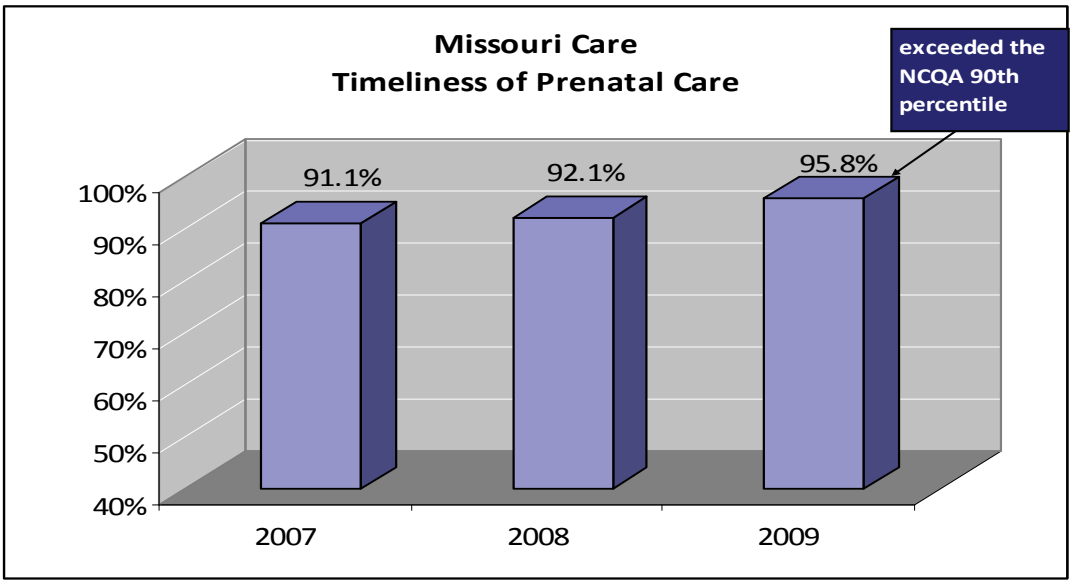
Missouri Care also contracted with a home health agency to provide

home visits to pregnant members identified as having high risk factors.

Missouri Care further expanded this initiative to include a teen pregnancy Case Manager who was funded through a grant developed in partnership with several community agencies and Heartland Health. This Case Manager monitors the Plan of Care for pregnant teens, serves as a liaison to the medical community, and networks with teens not attached to any educational setting. Home visits, along with group opportunities, are provided during the prenatal period and until the child is two years of age.

Outcomes

As a result of the targeted interventions described above, our Missouri Care program experienced a 20% reduction in low birth weight babies. Additionally, as demonstrated by the graph below, Missouri Care's rate of timeliness of prenatal care, as measured by HEDIS, demonstrated continuous improvement and exceeded the NCQA 90th percentile in 2009.



Example Three – Reducing Inappropriate Emergency Department and Hospital Admissions

Aetna Better Health recognizes that improved access to preventive care increases the continuity and quality of care while reducing overall system costs. To that end, one of our priorities is to provide each member with the right service, at the right time, at the right level of care.

Aetna Better Health recognizes that members have better outcomes when they establish a relationship with a Primary Care Provider (PCP) as their medical home. Members who are connected to their PCPs are less likely to experience a hospital admission due to a chronic condition that can be treated in their medical home, and are also less likely to be readmitted to the hospital for the same condition.

Issue Identification

Aetna Better Health realizes that reducing unnecessary ED visits is a challenging issue for all health care systems. Nationwide, the numbers of ED visits are increasing at a steady pace with

Medicaid recipients making up the largest portion of utilizers. From 1999 to 2007, ED visit rates for Medicaid enrollees rose 36% from 694/1000 to 947/1000 enrollees nationally.

Through its QAPI program, Aetna Better Health routinely reviews member utilization data to detect under and over utilization of services. We use this information to identify members in need of additional supports or the need to make systemic improvements to the service delivery system. Additionally, we routinely monitor HEDIS rates for ED visits per 1000 members and ED visits for members with ambulatory sensitive conditions. Further review of these data revealed that the top 10 diagnoses for members presenting to Emergency Departments include:

- Upper respiratory infection
- Otitis media
- Pharyngitis
- Viral infection
- Gastroenteritis
- Abdominal pain
- Fever
- Bronchitis
- Headache
- Urinary tract infection

As these conditions are best treated in ambulatory care settings, Aetna Better Health determined the need to develop interventions to support members receiving care in more appropriate, cost effective settings.

Root Cause Analysis

To identify barriers to members accessing care through their PCP, Aetna Better Health reviewed case management, utilization, and administrative data to identify inappropriate hospital admissions for frequently occurring diagnoses such as asthma, diabetes, vomiting/GI illnesses, otitis media, etc. We then conducted a barrier analysis with each of our affiliated health plans to identify the barriers and targeted interventions.

- Low member health literacy
- Parent/caregiver lack of confidence in their ability to care for a child with a minor illness
- Lack of temporary or permanent housing
- Member inability to navigate the healthcare system
- Coordination of care -Lack of PCP utilization
- Challenge in locating/contacting these members
- Increased ED utilization for members with co-morbid behavioral health conditions
- Lack of PCP after hours coverage

Aetna Better Health also trains its member services and care management personnel to identify potential obstacles to care during member communications opportunities and to work with family members/caregivers, PCPs and other relevant entities to provide access to services. We

track and trend this information for report to the QMUM Committee for review and recommendations on interventions to reduce inappropriate hospital utilization.

Improvements

Aetna Better Health supports access to services along the health care continuum based upon the member's needs. We know that the overall health status of the member can be enhanced through the establishment of a health care home versus the episodic care available in an Emergency Department (ED). To that end, we have developed a comprehensive array of programs to reduce inappropriate use of ED services, including member and provider education, expansion of the network, frequent monitoring of utilization data, performance improvement activities, Integrated Care Management, and our Disease Management program. To reduce inappropriate hospital utilization, including admissions for ambulatory care sensitive conditions and ED visits, Aetna Better Health implemented an impactable admissions program designed to connect members to the right service in the right place, at the right time.

Aetna Better Health's impactable admissions program reduced avoidable admissions by 10%.

We believe that by engaging members and their families to play an active role in their health care, assisting the member in navigating the delivery system, and coordinating care between service providers and service, settings, we can improve member health outcomes and reduce unnecessary costs associated with avoidable hospitalizations and readmissions. Aetna Better Health, and our affiliated health plans developed interventions based on the specific needs of our members across the nation to address barriers impacting reductions in hospitalizations and readmissions, by:

- Educating PCPs on evidence-based guidelines and best practices
- Meeting with ED physicians to discuss alternative approaches to promoting primary care within the ED
- Developing targeted care plans for hospitalized members to facilitate access to ambulatory care services
- Monitoring the availability of PCP after hours coverage
- Identifying patients with co-morbid physical and behavioral conditions with the highest use of the ED and hospitals and developing targeted case plans
- Targeting network expansion to increase the number of PCPs with after hours coverage
- Expanding our network of more cost-effective urgent care providers
- Developing protocols for identifying and managing members who present at the ED with the intention of obtaining narcotics or other pharmaceuticals subject to abuse (e.g., Recipient Lock-in Program)
- Referring members accessing EDs for the purpose of obtaining medications subject to abuse for substance abuse or pain management services
- Case management collaboration with behavioral health providers to co-manage- members with behavioral health conditions
- Addressing member-specific issues such as lack of transportation or language barriers

- Educating members on available disease and chronic care management programs
- Requiring providers to have an on-call system which requires providers to either respond directly to the member within 30 minutes, or have a qualified medical professional available who will respond within that timeframe.

All of our health plans are intervening at the member level to implement substantive interventions to reduce inappropriate ED utilization, such as

- Co-case management of members with behavioral conditions (with BH-MCOs) to address transportation, language or other barriers to accessing care.
- Reviewing doctor visits immediately prior to an ED visit to assess physician adherence to evidence-based guidelines, resulting in poor after hours care.
- Meeting with ED physicians to discuss alternative approaches within the ED to promote primary care.
- Reviewing all ED and hospital utilization for all currently hospitalized patients and developing plans of care that enhanced access.

Outcomes

In its first year, Aetna Better Health's Impactable Admissions Program (IAP) achieved an overall 10 percent reduction in avoidable admissions (ranging from 3 percent to 21 percent across eight health plans), resulting in both significant savings and improvements in quality of care. In the process, readmissions were also decreased by two percent. With the average cost of readmission being $5,581 across our plans, the potential cost savings associated with this initiative is substantial.

Health Plan Initiatives

In addition to the initiatives described above, our plans have developed innovative programs to address inappropriate hospital utilization for members with chronic conditions. We highlight Delaware's program to reduce admissions for members with Congestive Heart Failure, and Missouri's program for members with asthma below.

Reducing Hospitalizations for Members with Congestive Heart Failure - Delaware

An Aetna Better Health Affiliate, Delaware Physicians Care (DPCI), a Managed Care Medicaid Plan, initiated a targeted improvement plan when its analysis of claims data showed that 60% of their inpatient costs for members with cardiovascular disease were caused by 40% of patients with multiple inpatient stays and emergency room encounters.

To improve access to care for members with a history of heart failure, DPCI collaborated with one of the largest health care providers in the mid-Atlantic region, to determine if early and ongoing intervention using tele-health in Medicaid members with CHF would reduce hospitalization and emergency room encounters. A pilot study was implemented to provide in-home tele-monitoring to members with CHF. The plan included identification of members who met the selection criteria for the intervention and standardized telephonic visit modules for patient education.

DPCI's (Aetna Better Health affiliate) Control Your Heart for the Future program saved the Medicaid program $113, 051

The **C**ontrol your **H**eart for the **F**uture cross-functional workgroup met weekly, then bi-weekly and finally monthly for ongoing joint decision-making to ensure that the pilot remained on target. Based on the pilot program framework, interventions included:

- Member letter solidifying the member's agreement to participate in the **C**ontrol your **H**eart for the **F**uture pilot program for 12-13 weeks
- Provider letter informing the PCP and Cardiologist of the **C**ontrol your **H**eart for the **F**uture pilot program, asking for their support given that a member of their panel had agreed to participate.
- PCP and Cardiologist Provider Outreach calls by another Medical Director to introduce the program and solicit their buy-in.
- In-home monitoring with Field Based Case Management
- Obtain land lines for members without phones compatible with the in-home monitoring equipment
- Obtain scales and blood pressure cuffs for members to sustain self-management activities

Outcomes

Pre and post financial information showed significant cost savings and the effectiveness of in-home monitoring with field-based case management coordination. Both the member clinical outcomes and member quality of life outcomes indicate that for this cohort of members, in-home monitoring with field based case management results in members being better able to self-manage their condition and incurring less inpatient hospitalizations and ED visits, resulting in a cost savings of $113,051 for the Medicaid program.

Reducing Hospitalizations for Members with Asthma - Missouri

Our Missouri Care subsidiary, Missouri Care, implemented an asthma management program that resulted in a 46% reduction in emergency room visits per member per year and a reduction of $146 in costs per member per month. To accomplish this, Missouri Care, using Asthma-specific interventions, developed and implemented a PIP targeted at members diagnosed with Asthma in an effort to reduce ED utilization and promote positive health outcomes. Since controller drugs used on a daily basis by patients with persistent Asthma have shown to reduce exacerbations requiring emergency care and hospitalization, the purpose of this PIP was to increase the percentage of Missouri Care members who are correctly taking the appropriate medications (i.e., controller medications).

Missouri Care's (Aetna better Health affiliate) asthma management program resulted in a 46% reduction in emergency room visits per member per year.

As part of this initiative, our Missouri subsidiary, Missouri Care, partnered with a local physician group to improve their program for asthma management for both our adult and child members. Under the program, Missouri Care provided PCPs with 1) formal training; 2) asthma guidelines and sample asthma action plans to use with members; and 3) quarterly roster mailings identifying their members with persistent asthma but without a fill for controller medications. Missouri Care mailed quarterly member lists to primary care providers of members who, based on claims data, had persistent asthma but who have not had a fill for a controller medication in the previous 12 months. The list was sent to the members' primary care

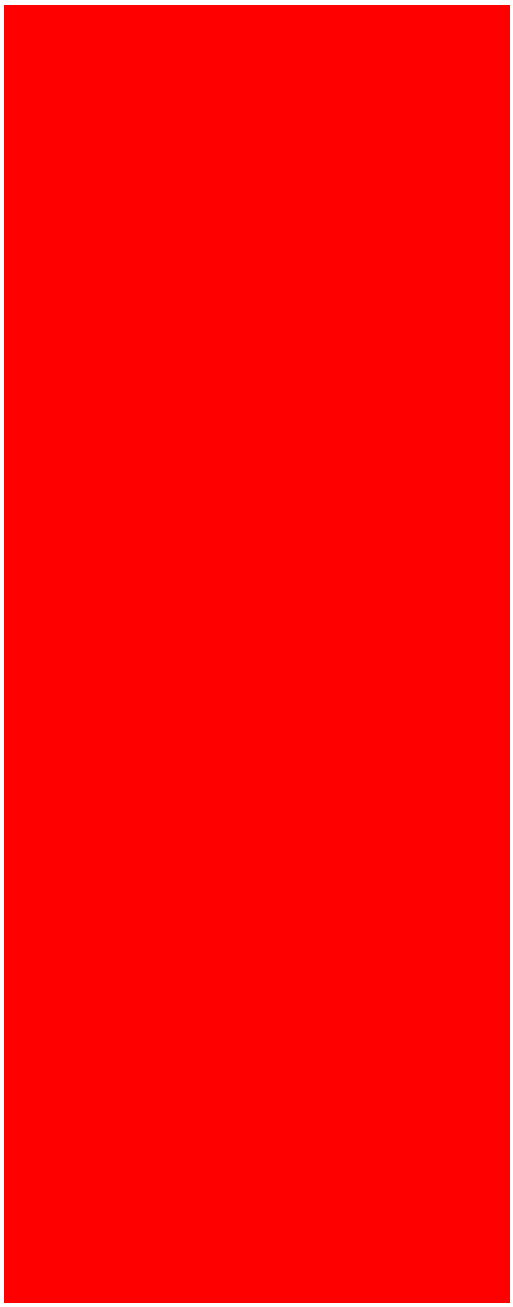
provider along with a cover letter educating the provider on current asthma guidelines, encouraging the use of asthma action plans and referring them to the national NAEPP guidelines. Copies of the guidelines were sent with the first mailing and a sample asthma action plan was sent with every mailing. A concurrent review nurse attempts to contact any member hospitalized with an asthma diagnosis following their discharge to assure that the member fills and properly takes their medications. Members in case management with a diagnosis of asthma were educated on proper medication adherence. Additionally, the Plan's Quality Management Department sent letters to members who met the HEDIS criteria for persistent asthma and have not had a controller fill to encourage these members to schedule appointments with their providers. Missouri Care's Medical Director also phoned providers when members were identified as discharged from the hospital for asthma exacerbation without a controller medication.

Outcomes

This initiative resulted in cost-savings for the health plan and Medicaid program due to a reduction in avoidable inpatient admissions. To evaluate the effectiveness of its interventions, Missouri Care conducted an outcome analysis of our asthma program for emergency department (ED) visits, PCP visits and inpatient (IP) admissions by comparing pre- and post-enrollment data for members in our asthma program. As shown in the table below, the resulting data demonstrated that ED visits and IP admissions decreased and PCP visits remained stable during both periods.

Aetna Better Health (2008-2010)	Asthma	
	Pre DM	Post DM
ED visits per member/year	3.7	1.7
PCP visits per member/year	6.7	6.6
Inpatient admits per member/year	11	0
Cost PMPM	$259	$113

89 J.5



J.5 Describe your proposed Quality Assessment and Performance Improvement (QAPI). Such description should address:

- **The PIPs proposed to be implemented during the term of the contract.**
- **How the proposed PIPs will expand quality improvement services.**
- **How the proposed PIPs will improve the health care status of the Louisiana Medicaid population.**
- **Rationale for selecting the particular programs including the identification of particular health care problems and issues identified within the Louisiana Medicaid population that each program will address and the underlying cause(s) of such problems and issues.**
- **How you will keep DHH informed of PIPs program actions, recommendations and outcomes on an ongoing and timely manner.**
- **How the proposed PIPs may include, but is not necessarily, limited to the following:**
  - **New innovative programs and processes.**
  - **Contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts and/or School Based Health Clinics.**

Aetna Better Health is committed to maintaining a member-focused, innovative, and adaptable care system that provides the highest quality of care in an efficient and effective manner. We have a comprehensive Quality Assessment and Performance Improvement (QAPI) program to evaluate and improve the services and quality of care provided to all members, including specialty populations (e.g. members with special health care needs, pregnant women). We accomplish this by: 1) promoting the use of evidence-based guidelines, targeted benchmarks, and performance measures; 2) continuously assessing and improving all aspects of care and services; and 3) partnering with the Department of Health and Hospitals (DHH), our providers and community organizations to improve members' health outcomes.

The foundation of our Quality Assessment and Performance Improvement (QAPI) program is our QAPI Plan. The QAPI Plan will support Aetna Better Health's strategic plan and goals, the DHH's quality strategy, quality plan, and other contract requirements. Annually reviewed and approved by our Board, the QAPI plan provides the administrative and functional framework for our quality and performance improvement activities, including but not limited to:

- Identifying and selecting Performance Improvement Project (PIP) topics
- Inter-department communication, cooperation, and coordination
- Evaluating effectiveness of our interventions; and
- Guiding our processes for assessing clinical and non-clinical processes.

Our QAPI plan provides a coordinated strategy for implementing the QAPI program, including our structure for decision-making, developing and implementing interventions and assessing of results. The plan also provides the framework for communicating QAPI program goals throughout the organization including staff training and organization. Through the plan we define our processes and approach for our QAPI program, including our methods for evaluating

the effectiveness and impact of our QAPI program, and incorporating feedback from members, providers, and other stakeholders into the development of our QAPI program.

Aetna Better Health designs it QAPI program, consistent with our ten other Medicaid managed care contracts, to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and promotes improved patient outcomes through monitoring and evaluation activities. Through our QAPI program we define, identify, and implement improvement activities to enhance our clinical and program efficiency, provide effective utilization and identify opportunities to improve outcome management to achieve meaningful advancement of our quality goals. Improvement methods include, but are not limited to, performance improvement projects, medical record audits, performance measures, and surveys. Additionally, Aetna Better Health's QAPI program is designed to:

1) Detect patterns of underutilization and overutilization of services; and
2) Assess the quality and appropriateness of care furnished to members with special health care needs.

Aetna Better Health uses the Plan-Do-Study-Act (PDSA) model to assess our processes for tracking, trending, analyzing, and acting upon performance measure, and surveillance data. Our PDSA approach involves leadership from Aetna Better Health's entire organization. Our Board of Directors (the Board) is ultimately responsible for all aspects of our quality management, including medical management program. This responsibility includes the evaluation and oversight of the efficiency, effectiveness and outcomes of the QAPI program. The Board provides strategic management direction to our QAPI program and evaluates the degree that the philosophy and scope of the QAPI program is incorporated within each operational/management unit and across Aetna Better Health's operations. The Board delegates day-to-day management of our quality management program to the Chief Executive Officer (CEO) who delegates responsibility and authority for our quality management program to our Chief Medical Officer (CMO). Our CMO has the responsibility and authority for overseeing all clinical indicator measures including the implementation of the annual QAPI work plan.

Our QAPI program receives feedback from our members and providers to continuously improve our programs, operations, and management approach. These program, operational, and management improvements lead to enhanced member health outcomes and efficiency of provider services. Our CMO has the support of our Aetna Medicaid Business Unit corporate Utilization Management (prior authorization, concurrent review, retrospective review), Case Management, Informatics, Information Technology (IT), Actuarial Services, and Claims, personnel to continually strengthen and improve our ability to develop, implement, monitor/evaluate, and replicate successful interventions to improve health outcomes and quality of care. We consider the collection of accurate, timely, and complete quality management data and results of clinical performance measures to be pivotal to developing successful interventions to improve health outcomes and quality of care. The Quality Management Coordinator supports the Medical Director by managing day-to-day performance measure related activities.

Quality management is a company-wide endeavor with our CMO leading the integration of interdepartmental monitoring processes and activities (such as those for referring quality of care/risk issues, member/practitioner complaints, grievances and appeals), business application

systems and databases across each functional or operational unit. Our quality program includes a structure of oversight committees with representation from across Aetna Better Health and includes community providers and members. Functional program areas and all our formal committees actively participate in identifying opportunities for quality improvement, at the individual member or provider and at the health plan level. The foundation of Aetna Better Health's processes is to enhance and implement our QAPI opportunities and interventions by establishing, reinforcing, and facilitating a cross-functional approach through leadership from our senior management team and consistent internal communication about QAPI activities through the committee structure.

Our executive leadership and management team responsible for Medical Management, Member Services, Case Management, Network Development and Contracting, and Provider Services are responsible for disseminating, orientating, and training personnel about the value and importance of our QAPI programs, activities and outcomes. As part of the required annual performance assessment, we evaluate and document strategies, activities, communication, and feedback that each segment of the management team contributed to Aetna Better Health QAPI program. This health plan wide endeavor occurs through our Quality Management Oversight Committee (QMOC).

The QMOC, a multi-disciplinary committee chaired by our CEO with information reported to the Board, regularly monitors and reviews performance measure outcomes and makes recommendations on cross-departmental strategies to improve quality of care and/or to determine if additional quality indicator measures are necessary to measure program performance. The Quality Management/Utilization Management Committee (QM/UM) chaired by the CMO, serves as an integrating forum where key personnel from all functional areas within the organization systematically review data, identify opportunities for improvement, make recommendations for system enhancements and process improvements, and track initiatives to completion. The QM/UM Committee meets quarterly and is responsible for the identification of quality improvement opportunities, the finalization of intervention strategies to improve quality and cost effectiveness across the continuum of care, and integration of the QAPI program throughout the organization.

Aetna Better Health's CMO, with the support of the Quality Management Coordinator and Performance Improvement Coordinator manages and directs the selection, design, implementation, and evaluation of each PIP. This workgroup collaborates with executive and management personnel to make certain that each PIP complies with DHH's requirements, follows federal protocols, and adheres to CMS and NCQA standards. Under the supervision of the CMO, the Quality Management Department, led by the Quality Management Coordinator is responsible for implementing, managing, tracking, and reporting PIP activities.

Under the leadership of the CMO, the Quality Management Department prepares a PIP proposal for review by the QM/UM Committee. This committee selects each PIP topic based on:

a) Objective performance indicators including DHH performance measures

b) Quality of care concerns including trends from peer review

c) Member's demographic characteristics and health risks

d) Prevalence of the chosen topic or condition within our membership

e) Member and caregiver input

f) Provider input

g) Input from advocacy organizations or similar community stakeholder

h) Utilization management activities; and

i) Trends identified through network/performance monitoring, results of credentialing/re-credentialing, utilization management outcomes and actuarial analysis (member/provider profiling).

Topic areas that address improved care for high risk members and appropriate utilization of high volume services receive priority in selection of QAPI activities. An overriding selection factor is our ability to achieve significant improvement sustainable over time in clinical care and non-clinical care areas through the selected topic. After selecting a PIP topic, the QM/UM Committee submits the PIP proposal for review and approval by the Quality Management Oversight Committee (QMOC) and the Board. It is our standard operating procedure to design each PIP to achieve significant improvement, sustainable over time that have positive effects on health outcomes of our members or will improve member or provider satisfaction. Therefore, each PIP will involve the following elements:

- Performance measurement using objective quality indicators;
- Implementation of system interventions to achieve improvement in quality;
- Evaluation of the effectiveness of the interventions; and
- Planning and initiation of activities for increasing or sustaining improvement

The QAPI Program's written policies and procedures address components of effective healthcare management and define processes for ongoing monitoring and evaluation that promote quality of care. Aetna Better Health's underlying strategy focuses on continuous improvement and allows us to rapidly intervene when data monitoring reveals inconsistencies in care, or responding to member or provider concerns.

Aetna Better Health employs data driven clinical initiatives to improve members' access to health care, health status and overall quality of life by delivering high quality and cost-effective health care services. We have a long-standing history of implementing innovative programs for care coordination, chronic disease management, implementing patient-centered medical homes, and improving access to care in our Medicaid programs. We leverage our state-of-the-art data systems to identify opportunities for improvement and develop performance improvement goals through our QAPI program that facilitate and support the state's quality of care goals.

One of our major sources of utilization data is claims and encounters data. These data are our most significant source of information for the evaluation/monitoring and reporting of utilization patterns.

We augment claims data with prior authorization (PA) information, from both our PA Department and information from our Integrated Care Management (ICM). Both the claims data and encounters are treated the same by our Actuarial Services Data Base (ASDB) - our claims

warehouse. ASDB supports our reporting and analytical needs, such as our multidimensional predictive modeling and statistical outlier analysis. ASBD includes eligibility, provider, prior authorization, pharmacy, and claims data and serves as a key data source for medical management. Analyst from Informatics Department use the proprietary Actuarial Analytics Web Portal (AAWeb), an interactive interface, as a point-and-click query tool to access reports; drill down into data and export information from ASDB. For instance, AAWeb can generate customized analyses to identify favorable and unfavorable cost and utilization trends, measure performance against key benchmarks, and provide summary information. It is a powerful tool that supports our QAPI program and provides our leadership with access to member/provider cost and utilization trends that are used in identifying potential PIP topics.

Aetna Better Health's approach to developing PIP interventions to improve care and services occurs through the QM/UM Committee whose membership includes representatives from our managerial, operational, information technology, quality, and utilization personnel. The responsibilities of the QM/UM Committee are to: 1) direct and review quality improvement activities; 2) review data and propose evidence-based interventions; 3) designate evaluation and study design procedures; 4) identify task forces/committees to review areas of concern in the provision of healthcare services to members; 5) analyze periodic members' service utilization patterns; 6) share results and information on the QAPI program cross-functionally throughout the Plan; and7) determine that the intended PIP outcome is reasonably attributed to the planned interventions. Our process is iterative, multi-departmental, and multi-disciplinary; the exchange of information and ideas during this process is instrumental to the effectiveness of our interventions. This enables each core department to have input into design of the interventions. The QM/UM Committee reports its findings and recommendations to the QMOC who reports to the Board for review, amendment and final approval.

Aetna Better Health's affiliated plans have been recognized for strong performance and continue to conduct successful PIPs that are designed to achieve demonstrable improvement in the quality or appropriateness of services provision and to sustain the improvement over time. All our PIPs follow CMS protocols and utilize the four step Shewhart quality management cycle – Plan-Do-Study-Act to achieve rapid cycle improvement. We will leverage our proven track record in this area to develop PIPs that will improve health outcomes for members served by our Louisiana Medicaid program.

Proposed QAPIs

Aetna Better Health recognizes that improved access to preventive care increases the continuity and quality of care provided to our members while reducing overall system costs. To that end, one of our priorities is to provide each member with the right service, at the right time, at the right level of care. To facilitate this goal, we propose to implement two QAPIs in year one of the contract that align with performance improvement projects outlined in Appendix DD of the RFP: 1) reducing unnecessary hospital visits and admissions ; and 2) improving access to care for pregnant women and newborns.

PROPOSED QAPI 1: REDUCING UNNECESSARY HOSPITAL VISITS AND ADMISSIONS

In support of Louisiana Medicaid program goals to reduce the high rates of emergency department visits, avoidable hospital stays and readmissions, Aetna Better Health proposes to implement a Performance Improvement Project to identify high risk members and connect them with the right service at the right time, thus reducing inappropriate hospital utilization.

In our experience, focusing improvement efforts primarily on reducing ED visits alone does not impact member health outcomes and result in the highest cost savings. Instead, we have found that a multi-pronged approach that 1) identifies high ED utilizers for the purpose of connecting them with the right services to meet their needs through our intensive care management program, 2) providing additional supports for members with chronic conditions through our disease management program, and 3) reducing member readmissions through a comprehensive discharge planning process results in improved member outcomes and overall cost savings for the Medicaid program.

In designing the proposed interventions for this study, Aetna Better Health relied on its experience in other Medicaid programs and the barriers identified, which include:

- Member health literacy
- Parent/caregiver lack of confidence in their ability to care for a child with a minor illness
- Lack of temporary or permanent housing
- Member inability to navigate the healthcare system
- Coordination of care
- Lack of Primary Care Provider (PCP) utilization
- Challenges in locating/contacting these members
- Increased ED utilization for members with co-morbid behavioral health conditions
- Lack of PCP after hours coverage

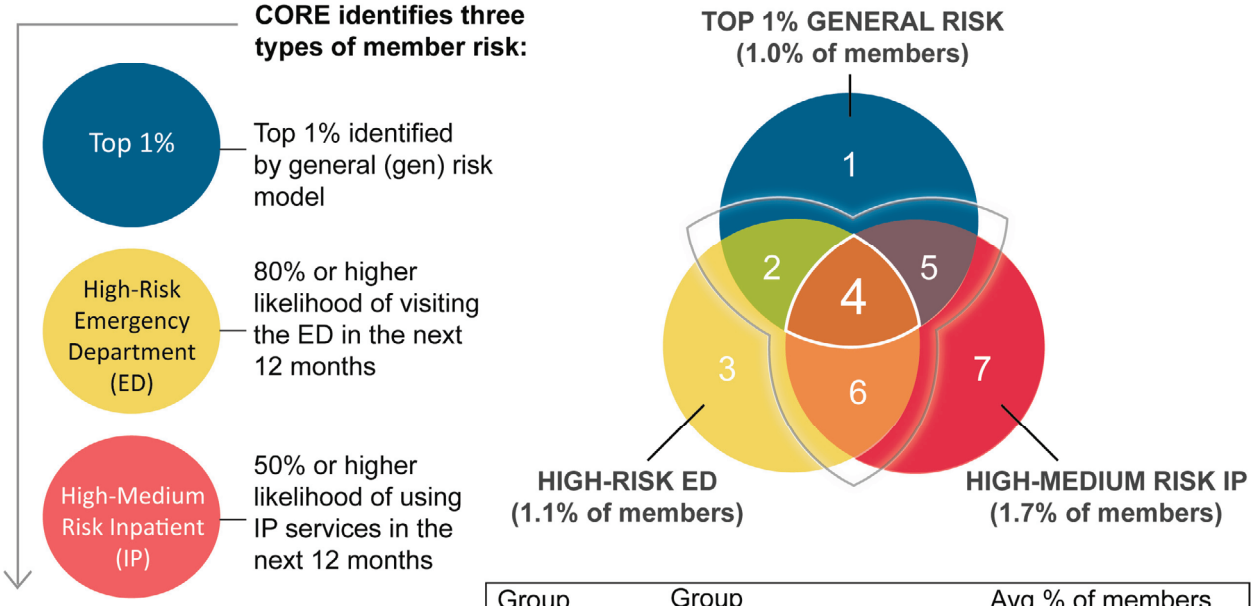
Based on improvements realized as a result of these interventions in our other Medicaid programs, we propose to implement our successful Intensive Care Management (ICM), Disease Management (DM), and Readmissions programs to reduce inappropriate hospitalizations for our members in Louisiana.

Expanding Quality Services

Aetna Better Health's daily work is to provide members with the right services in the right place, at the right time. Our ICM, DM, and Readmissions programs comprise a vast array of resources that our available for our personnel to identify members who would benefit from additional care coordination while offering our members the support they need to manage their health care and improve health outcomes. Our programs go beyond the traditional disease management or case management approaches in proactively identifying members through the Consolidated Outreach and Risk Evaluation (CORE), our state-of-the-art tool for predictive modeling. This tool uses historical claims data to prospectively identify members who are at high risk of having adverse outcome in the near future. Our predictive modeling tool includes our proprietary predictive

modeling software that uses medical and pharmacy claims data to predict a member's future risk probability. The outcome of this analysis feeds our comprehensive Consolidated Outreach and Risk Evaluation or CORE model. The CORE identifies three types of risk: 1) high risk Emergency Department (ED), defined as an 80 percent or higher likelihood of visiting the ED in the next 12 months; 2) high-medium risk inpatient (IP), defined as a 50 percent or higher likelihood of using IP services in the next 12 months; and 3) the top one percent of members identified as high-risk. Because there is significant overlap between these three risk groups, we represent these groups visually as a Venn diagrams (see diagram below).

Aetna Medicaid's Consolidated Outreach and Risk Evaluation (CORE) tool identifies members who will benefit most from our Integrated Care Management program. This tool uses acute care, pharmacy and long-term care (LTC) claims data to identify members at high risk for adverse future health outcomes.



Identifying highest risk members

This diagram shows three risk categories. The areas of overlap represent members at high risk (groups 2, 4, 5 and 6) for adverse health outcomes. Group 4 represents members at the highest risk, falling into all three risk categories.

Group #	Group name	Avg.% of members for typical health plan
1	Top 1% Gen risk ONLY	0.6%
2	Top 1% Gen risk / High-risk ED	<0.1%
3	High-risk ED ONLY	0.3%
4	High-med risk IP/Top 1% Gen risk/High-risk ED	0.2%
5	Top 1% Gen risk / High-med risk IP	0.2%
6	High-risk ED / High-med risk IP	0.6%
7	High-med risk IP ONLY	0.7%
	Percentage of members not in CORE:	97.4%

Note: Percentages may not add up to 100% due to rounding

With the CORE as our foundation for identifying members and assigning them to the most appropriate level of support to meet their unique needs, we are able to design effective interventions that result in improved member outcomes and realized cost savings, whether the member is served through ICM, DM, or participating in our Readmissions program.

Integrated Care Management

Our Integrated Care Management (ICM) is a means to provide continuity of care through a holistic and culturally competent approach. Aetna Better Health's ICM program matches members with the resources they need to establish a relationship with a PCP as their medical home, improve their health status and to sustain those improvements over time. Through ICM, Aetna Better Health addresses the needs of members who have multiple co-morbid, complex medical conditions or challenging social situations that make it difficult for members to navigate the health care system. We then address the needs of these individuals by offering a Health Home as a PCP selection option to improve member care management. Through the ICM program, we use evidence-based practices to identify members at high risk of visiting an ED in the next 12 months, and offer them intensive care management services built upon a collaborative relationship with a single clinical case manager, their caregivers and their primary provider. This relationship continues throughout the care management engagement.

Identifying Members for ICM

We identify members for our ICM Program through several approaches and resources. Members served in our ICM Program generally include women with high risk pregnancies and members with multiple chronic conditions (e.g., TBI, development delay, congenital anomalies, liver disease, epilepsy, cancer, mental illness and other chronic conditions), all of whom are at risk for inappropriate hospital utilization. Aetna Better Health uses several methods to identify members who access services through the ED and would benefit from intensive care management services, including:

- Members with:
  - Inpatient admissions including the following: 1) more than three unplanned admissions in six months; 2) any admissions related to ambulatory care sensitive conditions, 3) currently receiving services in an inpatient facility and is at high risk of readmission, and 4) complex discharge planning needs and follow-up services
  - ED utilization greater than three visits in six months
  - Inadequate medical home (e.g., lack of coordination, member does have documented visits with PCP or OB (if pregnant))
  - Complex social factors (e.g., unsafe living conditions)
  - Complex clinical co-morbidity (e.g., multiple Public Health and Behavioral Health diagnoses)
  - Multiple specialists (e.g., greater than three types of specialists whose services require coordination)
  - Evidence of five or more medications from different therapeutic classes
  - Life expectancy of less than 5 months, per their PCP
- Information provided on enrollment files
- Information received from internal and external sources such as State or community sponsored programs, welcome calls, and prevention and wellness outreach activities
- Referrals from our PCP network, service and specialty providers, schools, community-based organizations, members and their families

- Health Risk Questionnaire (HRQ), which is conducted within 90 days of enrollment, provides self-reported information resulting in member identification
- Surveillance methods such as complaints and appeals, pharmacy management, quality management, prior authorization and concurrent review activities are also used for case identification
- Consolidated Outreach and Risk Evaluation (CORE) analysis using proprietary, evidence-based analysis of claims data to prospectively identify members and assign risk levels.

Once we identify candidates for ICM we perform a clinical triage to refer each member either to intensive or supportive Care Management. Our predictive modeling and self-report tools fully integrate physical and behavioral health conditions along with psychosocial risks and protective factors to identify members who would benefit from care management, and then stratify them into intensive and supportive levels of service. As demonstrated in the graphic above, members that are at risk for ED visits and inpatient admissions are considered to be in the top highest rank members, indicating the need for intensive care management services through the ICM program.

The ICM model enhances the member's experience by focusing on the following guiding principles:

- *Move from disease focus to member focus*: We evaluate every member for physical, behavioral, and social risks to their current and future health and holistically integrate and coordinate healthcare services that support individual members' physical and social needs.
- *Identify and employ the most effective intensity of evidence-based, covered systems and services*: We facilitate access to a continuum of services based on the intensity and complexity of each member's needs.
- *Employ behavioral engagement for change*: The case manager as the single point of contact to engage each member, as well as their responsible parties, in the development of an approach to address the member's physical and social needs to promote resiliency.
- *Team with the member and their responsible parties and PCP to enhance care outcomes*: We work together with the member, the member's PCP, and caregivers as an interdisciplinary team that emphasizes core competencies in physical health within a systems framework.

Assessment, Case Formulation and Care Planning

The reports and CORE process identified above are key elements in the identification of members at risk of or in an active disease state. In addition, we often identify or confirm our identification using system tools, through internal referral (PA, Concurrent Review, Case Manager), PCP/Patient-Centered Medical Home or self-referral – including care giver. . The ICM model is a natural extension of our commitment to improve our members' health outcomes, enhancing their quality of life and reducing racial and ethnic health disparities by providing needed care in the most appropriate setting.

Once a member is determined to need intensive care management services, a highly skilled case manager conducts an interview to identify the root causes driving poor health and the critical barriers to improvement. These might be related to their physical health or behavioral health conditions directly, to psychosocial issues that impact the member's ability to participate effectively in their own care, or to barriers created by the health care system itself.

Through ICM we assess the following areas to design of the member's healthcare plan of care:

1) Clinical history and utilization
2) Member's functional level
3) Living environment and support mechanisms
4) Medications
5) Member's self-care
6) Providers and other services
7) Perinatal

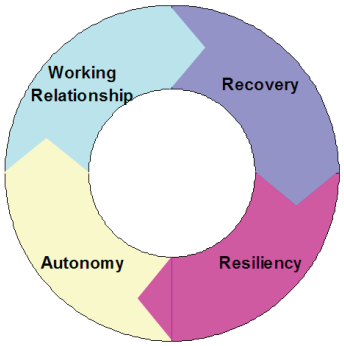
Our assessment of these areas services as the basis for the case formulation and case plan.

Working closely with the member, the member's caregiver and PCP, we use the plan of care as a roadmap to help guide the member through the fragmented health care system to improve access and coordination of medically necessary and covered services. The member and case manager then collaborate to identify the highest priority issues, goals important to the member, and activities to reach those goals. We consider engaging and motivating members to make critical changes in persistent patterns of behavior and to assume greater responsibility for their health as care management progresses to be essential skills for our case managers.

Aetna Better Health's ICM program emphasizes building a trusting relationship between the Care Manager, the member, and the member's family or guardian, to facilitate identification of member's goals, strengths, needs, and challenges. The care plan provides: 1) the member and the member's family or guardian with a clear understanding of their goals and agreement to the selected service options; 2) a summary of the member's rights and responsibilities, including contact information and their complaint and appeals rights; 3) a point-of reference for all Aetna Better Health personnel to facilitate coordination of members' care; and 4) a road map for the member and the member's family or guardian to navigate the complex health care system.

Assessment and care plan development is an on-going and fluid process between the member and the member's family and guardian and Care Manager. A new assessment is conducted and a care plan is developed at least every 30 calendar days or more frequently if there is a change in the member's condition or upon the member's or the family or guardian's request. We value the assessment and care planning process because it is member-centered, leads to consistency of services, provides for care in the most integrated setting, and promotes positive health outcomes for our members. We engage the member, the member's family or guardian, PCP and other providers to actively participate in the assessment and care planning process. Our experience in working with members who have high cost, catastrophic conditions and high risk pregnancies indicates that including the member, member's family or guardians in the assessment and care planning process is critical to the success of the care plan in improving outcomes.

One of the primary goals of the ICM program is to teach the member self-management tools that allow them to progress from Recovery through Resiliency and to Autonomy phases of care management, and ultimately strive to "graduate" members out of care management. The diagram below demonstrates the process by which members move toward self-management.



1. Working Relationship
The member is engaged in an effective working relationship with a primary Case Manager.

2. Recovery
The member shows a sustained decrease in current avoidable utilization and problematic symptoms, as well as sustained progression toward optimal quality of life and reduction / moderation of risk factors.

3. Resiliency
The member decreases his/her risk of future utilization by decreasing current risk factors and enhancing current protective factors.

4. Autonomy
The member takes responsibility for his/her own health and wellbeing, including managing his/her own health conditions effectively.

Aetna Better Health's ICM Program results in improved clinical outcomes for our members, who as a result require fewer and less intensive health care services over time. As members move toward autonomy, their intensity of services begins to diminish. Through this process, our case managers connect members to their medical home and teach them how to access the right services at the right time, thus improving their ability to manage their health symptoms in appropriate settings, thereby improving health outcomes and reducing system costs.

Disease Management

In addition to the ICM program, Aetna Better Health maintains a disease management program provided by Schaller Anderson, LLC (Schaller) as part of a management agreement, to coordinate care for members with chronic conditions. Schaller has operated an NCQA certified disease management program for targeted chronic diseases (e.g., congestive heart failure, chronic obstructive pulmonary disease, depression, asthma, and diabetes) based on Evidence-Based Clinical Practice Guidelines since 2006. . It is our experience that greater emphasis on disease prevention and management of chronic conditions often results in improved health outcomes and quality of care, and a reduction in inappropriate hospital utilization.

Like the ICM program, Schaller's Disease Management (DM) program emphasizes self-management support while educating members and their families/caregivers on improving member healthcare outcomes by facilitating their relationship with a medical home. Our disease management program goals include to: 1) increase the number of members using their medications correctly, 2) reduce morbidity and mortality of the disease; 3) decrease the incidence of ED visits and hospital admissions/length of stay,4) engage the member and the member's family/caregiver in maintaining a member's wellness in the most integrated setting 5) teach self-management skills, and 6) support both the member and the PCP/provider in establishing a consistent relationship that improves adherence to the members' care plan.

Schaller's DM program also focuses on providers, and includes specific program elements for: 1) educating PCPs/providers regarding Evidence-Based Clinical Practice Guidelines and that

adherence to these guidelines improves members' health outcomes; 2) involving PCP/providers in the implementation and evaluation of the program through our QM/UM Committee; 3) monitoring PCPs/providers compliance with the Evidence-Based Clinical Practice Guidelines; 4) interventions to improve PCPs/providers compliance with Evidence-Based Clinical Practice Guidelines, including but not limited to, corrective action plans or individualized training with QM RN personnel, CMO, or designee.

Our voluntary comprehensive DM program includes the following: 1) reviewing the member's care plan to identify the results of the member assessment; 2) collaborating with the member and the member's family/caregiver to identify the member's goals for management of their disease/condition, quality of life expectations, and interventions founded on evidence-based guidelines to support those goals; 3) teaming with the member, and member's family/caregiver, assigned CM, and key providers (e.g., PCP, BH provider) to identify the member's needs and strengths implement successful interventions founded on evidence-based clinical guidelines and eliminate any barriers to care; 4) developing a care plan to address the member's critical physical, behavioral and social needs to promote resiliency, recovery and optimal self-management with specific member outcomes; 5) educating members about their chronic disease and effective tools for self-management and evaluating the effectiveness of this member education as it relates to the members' self-management of their disease; 6) promoting access to a continuum of services, including community services, based on the intensity and complexity of the member's needs; 7) monitoring member outcomes to assess the program's effectiveness; and 8) keeping the member's PCP informed about the member's enrollment in the Disease Management program and the disease management activities and outcomes.

In Aetna Better Health's experience, our DM program is instrumental in assisting members in receiving the right services at the right time and in the right place. As a result, our approach to DM has resulted in reductions in inappropriate hospitalization and improved member outcomes. We will apply this same proven, effective approach in implementing DM services for our Medicaid population in Louisiana.

Readmissions Program

Aetna Better Health believes that inappropriate hospitalizations can be further reduced by increasing the percentage of members with successful discharge from hospital settings. To that end, we have developed a Readmissions program to assist members in accessing ambulatory care upon discharge. The Readmission program complements the member-focused strategies of Aetna Better Health's DM and ICM programs by offering further interventions at the member level to connect members to the appropriate level of care and support. As a result of our interventions, Aetna Better Health has substantially reduced its readmission rate (9.8%) to less than half the national average of 20.8%. We propose to build on this success to further reduce inappropriate hospital use by our Louisiana Medicaid members.

The premise of our readmissions program is that readmission prevention begins with discharge planning on the day of admission, not on the day of discharge, and should address the root causes that led to the current admission. Through this program, our affiliated plans designate personnel, or teams of personnel to facilitate comprehensive discharge planning with the member and the member's family and/or caregivers, as appropriate.

Consist with our belief that discharge planning should begin at the time of admission, designated Aetna Better Health personnel take the following steps prior to the member's actual discharge date:

- Schedule follow-up visits with PCP/PCMH, specialist(s), BH, tests, and/or laboratories as necessary
- Document key discharge information, including:
  - Information about current admission, including tests/laboratory results
  - Medication summary including dosage, frequency and reason
  - Diet and exercise plans
  - Contact information for Discharge Advocate and member's case manager if applicable
  - Dates and times for scheduled follow-up visits with PCP/PCMH, specialist(s), BH, tests, and/or laboratories
  - "Red Flags" for the member to watch out for and plan for action
  - Checklist to confirm that member understands discharge instructions (confirm understanding by using teach back method)

On the day of discharge, our designated personnel provide post-discharge training with the member and their family/caregiver to explain any discharge instructions and paperwork, and answer any questions they may have. Within 72 hours after discharge, we then conduct a telephonic or home visit and complete an assessment to identify the member's needs for:

- DME
- Transportation
- Social Services
- Home Health
- Medications reconciliation
- ADL evaluation
- Confirm available support system – caregiver, family
- Depression screening, safety/fall evaluation (for certain members)
- Educations provided (verbal or printed materials if necessary)

We continue to reach out to the member as clinically indicated to prevent readmission (evidence based information suggests at least once weekly for 30 days) to follow up on any needs identified in the Needs Assessment, identify any additional needs based on changes in the member's status, provide education, and coordinate care with the member's PCP/specialist as needed.

Improving the health care status of the Louisiana Medicaid population

Aetna Better Health's ICM, DM and Readmissions Programs strive to connect members with the level of services that they need. We make these services available for all Aetna Better Health members, affording each of our members the opportunity to learn to self-manage their health needs while receiving the expertise and support of our highly trained personnel. These programs are flexible enough to allow members to receive the amount of support they need based on

changes in their health care status. Using this model, we have successfully engaged members in treatment in our Health Plans across the nation. In our experience, members who receive assistance and support in navigating the system and managing their health conditions access more appropriate services.

Further, participation in our ICM and DM programs improve clinical outcomes for our members, who as a result, require fewer and less intensive health care services over time. As members move toward autonomy, their intensity of services begins to diminish. Through this process, our case managers connect members to their medical home, and teach them how to access the right services at the right time, thus improving their ability to manage their health symptoms in appropriate settings. This results in improved health outcomes and reduced system costs.

Aetna Better Health recognizes that members have better outcomes when they establish a relationship with a PCP as their medical home. Members who visit their PCPs within 3 days of discharge from a hospital setting are less likely to be readmitted to the hospital for the same condition. Aetna Better Health's Readmissions program systematically evaluates and eliminates barriers to members receiving appropriate care in ambulatory care settings through provider and member education, expansion of the network and monitoring, and member-specific interventions. This program for comprehensive member discharge planning at the time of admission further supports the member in navigating the health care system to receive appropriate care, thus improving health outcomes. The Readmissions program also serves as a mechanism for identifying members that would benefit from more intensive supports such as provided by our ICM and DM programs. In this way, we provide members with the right services, in the right place, at the right time.

In Aetna Better Health's experience, the targeted and sustained member outreach, education, and care coordination by our ICM, DM, and Readmissions programs facilitate member access to PCP care by addressing real and perceived barriers to care. Furthermore, they empowers members by providing them with the tools to navigate the health care system and make appropriate decisions about their care going forward, leading to sustained improvement.

Rationale

Aetna Better Health realizes that reducing unnecessary ED visits is a challenging issue for all health care systems. Nationwide, the numbers of ED visits are increasing at a steady pace with Medicaid recipients making up the largest portion of utilizers. From 1999 to 2007, ED visit rates for Medicaid enrollees rose 36% from 694/1000 to 947/1000 enrollees nationally. This is particularly challenging in Louisiana where only 5% of adults and 35% of adolescents in the Medicaid program received preventative care per the last report, contributing to high ED utilization for members with ambulatory care sensitive conditions such as asthma. With the average cost of ED visits in Louisiana at $1000/visit, reductions in ED use would result in significant cost savings for the Medicaid program.

In addition to the rising rates of ED visits, nationally, the 30-day readmission rate for Medicaid patients aged 18-44 is 20.8%, indicating that, of members discharged from the hospital, more than 1 in 5 will be readmitted within a month. Furthermore, the 30-day readmission rate for Medicaid patients aged 45-64 is 24.4%, meaning that of members discharged from the hospital, almost 1 in 4 will be readmitted within a month. Therefore, focusing solely on ED visits as a

mechanism for reducing costs associated with hospitalizations is insufficient. With the average cost of readmission being $6252 in 2010 across our plans, the potential cost savings associated with this PIP is substantial.

PROPOSED QAPI 2: IMPROVING ACCESS TO CARE FOR PREGNANT WOMEN AND NEWBORNS

Aetna Better Health understands that the health of mothers and infants is vitally important to our nation, both as a reflection of a large portion of our population and as an indicator of the health status of the next generation. We recognize that pregnancy is one of the primary categories for Medicaid eligibility and deliveries account for almost 50 percent of Medicaid inpatient discharges. Although Medicaid has increased access to medical care for low-income pregnant women, the Medicaid population remains at high risk for poor pregnancy outcomes. In our experience, Medicaid members are far less likely than commercial or Medicare members to have stable housing, a reliable mailing address, a telephone, or a long-term relationship with a health care provider. Due to the potential for negative health outcomes in this population, assuring that pregnant women on Medicaid receive proper prenatal care is a priority for Aetna Better Health. We propose to continue the initiatives we have successfully implemented in our other Medicaid programs to improve access to care for pregnant women and newborns for our Louisiana Medicaid population.

Expanding Quality Services

In Aetna Better Health's experience, assisting members and their families in establishing relationships with their PCP facilitates access to ongoing preventive care for the member. We propose to implement multi-faceted strategies, proven to be successful in our other programs to improve access to care for pregnant women and newborns for our Louisiana Medicaid members. These strategies include: 1) identifying and addressing any real or perceived barriers to care; 2) member outreach and education; 3) member incentives; 4) case management; and 5) partnering with community organizations and schools.

Barriers

Understanding barriers to access is essential to seeing that members receive appropriate services, including regular preventive services. Aetna Better Health trains our member services and care management personnel to identify potential obstacles to care during member communication opportunities and to work with caregivers, PCPs and other relevant entities to address them. We find that, although most caregivers understand the importance of preventive care, many confront seemingly insurmountable barriers to readily comply with preventive care guidelines. Examples of barriers to preventive care that we have encountered include:

- Cultural or linguistic issues
- Lack of perceived need if children are not sick
- Lack of understanding of the benefits of preventive services
- Competing health-related issues or other family/work priorities
- Scheduling or other access issues
- Child care

- Access to transportation to attend appointments
- Having high risk conditions
- Substance abuse issues
- Health literacy
- Lack of provider adherence to clinical practice guidelines

Aetna Better Health also trains its member services and care management personnel to identify potential obstacles to care during member communications opportunities and to work with family members/caregivers, PCPs and other relevant entities to facilitate access to services. We routinely link members with services designed to enhance access to preventive services, including:

- Facilitating interpreter services
- Locating a provider who speaks a particular language
- Arranging transportation to medical appointments
- Connecting members with other needed community-based support services

Aetna Better Health's proposed member strategies focus on assisting members and their families in navigating the service delivery system. We intend to connect members with the right care in the right place and at the right time by aligning our processes to address system barriers that impede member access to care.

Throughout the course of this PIP, Aetna Better Health will utilize the PDSA model to identify barriers specific to the needs of our Louisiana members and target additional interventions to address those issues.

Member and Provider Education

Aetna Better Health takes several approaches and strategies in an effort to reach and educate our members and their caregivers about the importance and value of preventive services, including EPSDT services. Based on barriers we have identified in other states where we serve similar populations, Aetna Better Health proposes to implement the following provider and member education strategies to improve access to care for pregnant women and newborns:

- New Member Welcome Packets and Welcome Calls which in addition to providing information our services and provides members with assistance in accessing well-child services
- Member Handbooks, newsletters and on-hold messages
- Member outreach and education (including mailings, reminder cards for appointments due and missed appointments, and telephone calls)
- Researching returned member mailings in an effort to identify accurate contact information
- Contacting PCPs for assistance in locating members
- Coordinating with state and community organizations, including prenatal clinics and other prenatal care providers, to educate pregnant women and encourage well-child visits for infants
- Member incentive and rewards programs

- Including clinical practice guidelines for prenatal care and well-child standards in provider contracts
- Provider Manuals and newsletters
- Provider outreach and education, including on-site training at provider offices
- Provider Preventive Care Toolkit/CD, with preventive care information, resources and forms
- Eligibility look-up reminders (i.e., when providers check for member eligibility status, they are reminded of any screens due for members)
- Provider patient rosters of children due for a well-child appointment
- Provider letters containing information about HEDIS®[5] measures, screening, documentation and billing requirements
- Health Plan Web sites
- Community outreach initiatives, including, but not limited to:
  - Local health fairs
  - Collaboration with community-based organizations

Aetna Better Health uses alternative means of communication for our members whose learning styles are better served through visual or oral presentation approaches. We also offer our preventive educational materials and Member Handbook in alternative languages to meet the needs of our members who are more comfortable with materials in another language. To further address the needs of our members, we provide our personnel with annual cultural competency training and work with our providers to better understand differing cultural beliefs involving health and health care delivery.

Our commitment to an effective preventive health strategy is based on the principle that early detection is key to reducing costs and improving the health status of all of our members, in particular, that of pregnant women and newborns. To this end, we never require prior authorization for preventive care services.

We have more than 10 years of experience in developing and implementing programs that emphasize prevention and wellness and the importance of:

- A health care home
- Continuity of care
- Coordination of care
- Identification and utilization of appropriate community resources

Integration into Case Management Programs

Pregnant women and newborns may be referred and integrated into our Case Management Program for further assistance in accessing health care services to meet their needs. Aetna Better Health's case managers are responsible for coordinating and tracking prenatal care and well-child services, including services for children with special health care needs. Our case managers use a variety of care management tools (e.g., CORE™, our proprietary predictive modeling

[5] HEDIS® is a registered trademark of the National Committee for Quality Assurance.

application) and assessments to identify members in need of coordination of care and schedule targeted outreach calls and incorporate these services into the member's care plan. They enter information gathered from these discussions into our customized case management tracking application, to enable Case Managers to review a member's encounter history, schedule needed appointments and plan follow up activities.

Perinatal Case Management

Through its perinatal case management program, Aetna Better Health provides support services to enable high risk pregnant women to receive quality prenatal care and achieve a healthy birth outcome. These services have revealed the benefits to early identification and tracking to intervene with those at highest risk for chronic conditions, such as, diabetes, substance abuse, nutritional deficiencies, domestic violence, mental health concerns, and other perinatal and pediatric risks.

Aetna Better Health's Perinatal and Postpartum Case Management Program is designed to assess for high risk maternal and fetal issues and coordinate and manage the care of women with high risk pregnancies. We recognize that each member's pregnancy is a unique experience and many behavioral, social and medical factors can result in a high risk pregnancy. Aetna Better Health has established a comprehensive perinatal and postpartum care program to identify, track and coordinate the care of pregnant members, with a focus on attaining positive health outcomes for both the mother and her newborn. Our Perinatal and Postpartum Case Management Program provides case management to all pregnant members from their date of enrollment (new member) or pregnancy confirmation (existing members) through the 60-day postpartum period. Our overall goal is to assure that these individuals have access to high quality, cost effective prenatal care and timely identification and intervention for postpartum concerns.

Aetna Better Health understands that early identification is the first step toward improving birth outcomes. Early identification and case management intervention are critical to our program. Strategies we use to identify and refer pregnant members for perinatal case management include, but are not limited to, the following:

- All plan personnel understand and are educated about our high risk perinatal case management program. Any contact with plan personnel can generate a referral.
- Member services representatives are a frequent first contact point. They refer members who believe they are pregnant or who have questions about maternity-related services.
- Concurrent review/prior authorization personnel refer members who are or may be pregnant when they identify them in an inpatient setting or through pregnancy-related prior authorization requests.
- PCPs are required to refer members who are or may be pregnant.
- Fetal medicine/perinatologists refer pregnant women who are enrolled in our health plan.
- The member handbook and our Web site encourage pregnant members to self-refer. They may use the toll-free number or our Web site to contact the plan.
- Review of internal reports, such as Emergency Department utilization reports, to identify pregnant members accessing services through the ED.

Once the pregnant member is identified for case management services, Aetna Better Health's perinatal case managers work closely with all high risk members to develop a customized care plan that includes: 1) supporting the authorization of, and monitoring adherence care plans of pregnant women; 2) assessing for and resolving barriers; and 3) serving as a center point for communication among all involved parties and identifying community resources to assist members.

Our goal is to improve health outcomes for the mother and her newborn. For high risk pregnant women, we have found the following type of interventions to be most effective in leading to positive health outcomes:

- Assisting members in scheduling and attending prenatal visits. This may include more frequent visits with the OB, tests to monitor the medical problem, blood tests to check the levels of medication, amniocentesis, serial ultrasound examination and fetal monitoring.
- Providing an early referral to high risk OB providers for those women with multiple gestations, severe chronic illness, HIV, substance abuse or other mental health conditions (other than alcohol) or domestic violence issues.
- Enrolling members with a history of substance abuse in a treatment program and see that these women go to the "front of the line" for treatment.
- If there is history of prior delivery requiring NICU services, identifying the reason and determining if it is repeatable and/or preventable.
- Providing members who are anemic (a marker for poor nutrition) with iron supplements, conducting an in-depth review of eating habits and diet and provide an early referral to Women, Infants and Children program.

Aetna Better Health's customized case management tracking application provides perinatal case managers with the ability to track comprehensive information about each member enrolled in our Perinatal and Postpartum Case Management Program. One of our case management tool's innovative features is a perinatal risk assessment questionnaire that can identify a member's immediate needs, past and current obstetrical and medical history, and current behavioral or social risks, including substance abuse and domestic violence. The identified risks drive the design of the individualized care plan with interventions specific to each member's needs.

Postpartum Care

Aetna Better Health recognizes that appropriate care for pregnant women continues beyond the delivery through the postpartum period. Timely postpartum care is an essential component of promoting well-being for mothers and babies. The postpartum visit is an opportunity to identify physical and mental health issues, such as postpartum depression, as well as feeding and bonding issues. It is the optimal time for family planning to occur. Our Case Management Program supports this important health step by:

- Follow-up case management: Members enrolled in perinatal case management receive follow-up calls and assessments. These assessments are intended to identify potential maternal physical and mental health issues and assessment basics for the newborn.
- Education: All members enrolled in case management are educated throughout the case management period about the importance of postpartum care.

- Educational Materials: All new mothers receive the "You and Your New Baby Book" which contains helpful information for new moms and stresses the importance of postpartum care.
- Provider Education: Postpartum care is reimbursed under the OB Global Authorization and providers are encouraged to stress the importance of postpartum care to their patients.

Member Incentives

To reinforce prenatal and post partum care, Aetna Better Health proposes to offer a gift card incentive program for eligible pregnant members enrolled at least 43 days prior to delivery through 56 days after delivery. Our incentives will comply with state and federal limitations. Based on our successful Aetna Better Health Better Babies program, we propose to consider incentives for pregnant women who attend each of the following visits:

- An early identification visit in the 1st trimester (within first 12 weeks),
- A prenatal care visit in the 3rd trimester (34th week visit), and
- A postpartum visit (6-weeks after delivery).

Incentives may include a gift card redeemable at a local grocery or discount store, or a prepaid telephone card, MP3 downloads or other member reward. Another incentive we will consider offering is to provide members' families with vouchers for diapers upon completion of a determined umber of well child visits. This program has proven very successful in increasing access to care for pregnant women and newborns in other state Medicaid programs.

Text 4 Baby program

Aetna Better Health proposes to continue supporting the text4baby program, an educational program of the National Healthy Mothers, Healthy Babies Coalition, as an additional mechanism to improve the health literacy of pregnant women and connect them to preventive care services. Text4baby provides pregnant women and new moms with weekly educational information via free text. Aetna Better Health has implemented this program in another state and found that over 50 percent of our members had cell phones and were willing to receive health information through this mechanism, indicating that this program affords us with yet another venue for connecting members with valuable information to improve access to care and health outcomes.

Partnerships with External Entities

Aetna Better Health understands that high quality care includes the establishment of a medical home with a PCP. However, in areas where access issues impede preventive care, we seek partnerships with a broad array of additional supports, including, FQHCs and RHCs, WIC, day care centers, churches and other appropriate entities to enhance our members' access to preventive services. Consistent with our emphasis on a health care home, we tie reimbursement of these alternative providers to sharing documentation of the visit and any diagnostic outcomes with our health plans and the member's PCP. Using our experience in developing partnerships with community organizations in other states, we will pursue similar collaborations when serving our Louisiana Medicaid members.

Aetna Better Health has more than 20 years of experience in developing and implementing programs that integrate prevention, wellness, disease management and care coordination. To this end, we have successfully coordinated with public agencies serving the Medicaid population, including Title V and waiver program case managers, social service departments, nutrition programs such as WIC, local health departments, and community mental health agencies. Our

care coordination services are based on a set of member-centered, goal-oriented, culturally relevant activities designed to deliver needed services in a supportive and cost effective manner, including the development and dissemination of health education materials and the co-sponsorship of educational activities and programs.

Aetna Better Health has successfully established partnerships with the Women, Infants, and Children (WIC) program in other states to provide outreach to members who are overdue for their well child visits. In those programs, we identify children who are overdue for a well-child visit and generate a colorful flyer to place in the members' files at the county WIC office. When the member next visits the WIC office, the nutritionist will hand out the flyer and provide counseling on the importance of preventive health screenings and immunizations. In addition, the WIC office may notify us of the visit so that our personnel can conduct follow-up and assist with scheduling an appointment and arranging for transportation, if needed. To date, we have found that members enrolled in WIC are more likely to receive needed screenings and services than those who are not. Due to the success of this partnership in other states, Aetna Better Health will encourage its members to participate in the WIC program and will approach this collaboration in Louisiana.

Methods to Monitor Access to Care for Pregnant Women and Newborns

Aetna Better Health recognizes that outreach and education are critical first steps toward increasing screenings and participation, but it is equally important to monitor progress toward targeted objectives and, if necessary, to develop and implement corrective actions. Aetna Better Health routinely profiles its providers to evaluate their performance on clinical and non-clinical indicators, including adherence to preventive care standards. We include provider-level HEDIS measures as part of our provider profile, including measures related to prenatal and post-partum care and well-child visits. Providers who do not meet established performance standards on these measures will receive education on preventive care requirements. Continual failure on the part of the provider to meet preventive care standards may result in the provider developing a corrective action plan; ongoing and consistent follow-up with the provider to track improvement; sanctioning the provider by capping enrollment or taking other actions; including termination of the provider's contract.

Aetna Better Health identifies all eligible newborns, including children with special health care needs, and collects and tracks data to monitor the levels of screening and participation. We incorporate the American Academy of Pediatrics screening benchmarks into the monitoring process and share this information with members, providers, vendors, the State and other appropriate entities.

Aetna Better Health requires providers who deliver well child services to track these services and:

- Document each assessment on the appropriate tracking form so that the record is complete and readable
- Comply with the health plan's periodic review of standards, including chart reviews
- Comply with Minimum Medical Record Standards for Quality Management and EPSDT Guidelines and any other requirements
- Report all encounters on the claims submission form by recording the CPT preventive codes

Aetna Better Health conducts regularly scheduled medical record reviews to see that PCPs' medical records document all screenings and services provided to members and to verify compliance with established regulatory standards. During this review, we verify compliance with well-child visits and required screenings.

If provider records have missing information, Aetna Better Health educates providers on well-child requirements. Continual failure on the part of the provider to adequately maintain medical records can result in the provider developing a corrective action plan; ongoing and consistent follow-up with the provider to track improvement; sanctioning the provider by capping enrollment or taking other actions; including termination of the provider's contract.

Improving the health care status of the Louisiana Medicaid population.

Aetna Better Health's affiliated plans routinely score over the 50th and 75th percentiles on HEDIS measures for prenatal care, as demonstrated in the table below:

Timeliness of Prenatal Care – HEDIS Rates			
State	**2008**	**2009**	**NCQA Percentile**
Missouri	92.1%	95.80%	75th
Maryland	87.1%	89.70%	75th
Delaware	88.2%	88.20%	50th

Our success in this area is due to the fact that we recognize that access to early preventive care and early detection services is critical for pregnant women and newborns. We understand that an expectant mother who receives prenatal care is 75 percent more likely to deliver a healthy baby and that routine preventive care is critical for the child's ongoing health status. In fact, research shows that children with incomplete well-child care in the first 6 months of life are significantly more likely than children with complete care to visit an emergency department for an upper respiratory tract infection, gastroenteritis, or asthma. In fact, children with incomplete care are 60% more likely to visit an emergency department for any cause compared to children who are up-to-date on their well-child care.[6]

Children who receive well-child visits also benefit from access to screening for development delays and referrals to appropriate services. In addition, families of children who receive well-child care benefit also from enhanced nutrition and health education, leading to improved health outcomes for the entire family. Members who routinely access preventive care services establish relationships with their PCP and are less likely to access emergency services and have fewer inpatient admissions. Therefore, connecting pregnant women and newborns with the appropriate education and supports to access preventive care reduces costs, improves care, and improves member health outcomes.

[6] (Reference: Hakim RB, Ronsaville DS. Effect of compliance with health supervision guidelines among U.S. infants on emergency department visits. Arch Pediatric Adolescent Med. 2002;156:1015-1020.)

Rationale

Aetna Better Health supports the goals set forth in this RFP to improve member health outcomes through education and outreach, care coordination, and increased access to care. To that end, due to the potential for poor birth outcomes related to inadequate prenatal and post-partum care, including low birth weight, and infant mortality, Aetna Better Health has determined that improving access to care for pregnant women and newborns is a priority.

Further support for this PIP topic can be found in the 2006 Kids Count Data Book which ranked Louisiana 49th in overall child well-being. We also note that only 52 percent of eligible infants 0-15 months served by the Louisiana Medicaid program received the recommended six or more doctor visits last year, contributing to this state having the highest infant mortality rate in the country.

In our experience, pregnant women who receive appropriate prenatal care have healthier babies, improving health outcomes and reducing infant mortality rates. Therefore, Aetna Better Health proposes to apply its expertise in connecting members to the right service, at the right time, in the right place to increase access to care for pregnant women and newborns. We have successfully implemented our perinatal case management and member outreach programs in other states, to improve member access to preventive care, and will use these proven intervention to improve health outcomes for pregnant women and children served by the Louisiana Medicaid program.

QAPIs for Contract Years 2-5

Throughout the course of the contract, Aetna Better Health will perform systematic, consistent, ongoing collection and analysis of, accurate, valid, and reliable data to identify and evaluate opportunities for improvement. Our state-of-the-art information technology system will provide the data collection, storage, integration, validation and retrieval resources, and support for identifying, selecting, tracking, and analyzing data/information to facilitate our PIP development, study and evaluation efforts.

Aetna Better Health will use the results of its monitoring and evaluation of overall performance to assess our QAPI program. As part of our assessment process, we will distribute results of the PIP and QAPI program outcomes to internal personnel and our network. Our ongoing monitoring and evaluation process will include an annual assessment of the efficacy of each member and provider intervention(s). We will use these results to develop our work plan for the subsequent fiscal year, which forms the basis for the QAPI program activities for the next year. This will allow us to base improvements to our QAPI structure on the effectiveness and success of implemented, evidence-based interventions.

We will use these data to develop PIPs in compliance with DHH contractual or regulatory requirements, and/or nationally-recognized accreditation standards that reflect the needs of Aetna Better Health's membership. Study topics selected by Aetna Better Health will be based on analysis of encounter data, special reports, and data related to high-volume, high-cost, high-risk services and reflect the needs or issues of the plan's population in terms of age, disease categories, and special risk status. Based on our experience and current knowledge of the Louisiana Medicaid program, potential PIP topic areas may include Access to Perinatal Care or Improving Health Outcomes for members with chronic conditions (e.g. asthma, diabetes).

Keeping DHH informed of QAPI program activities

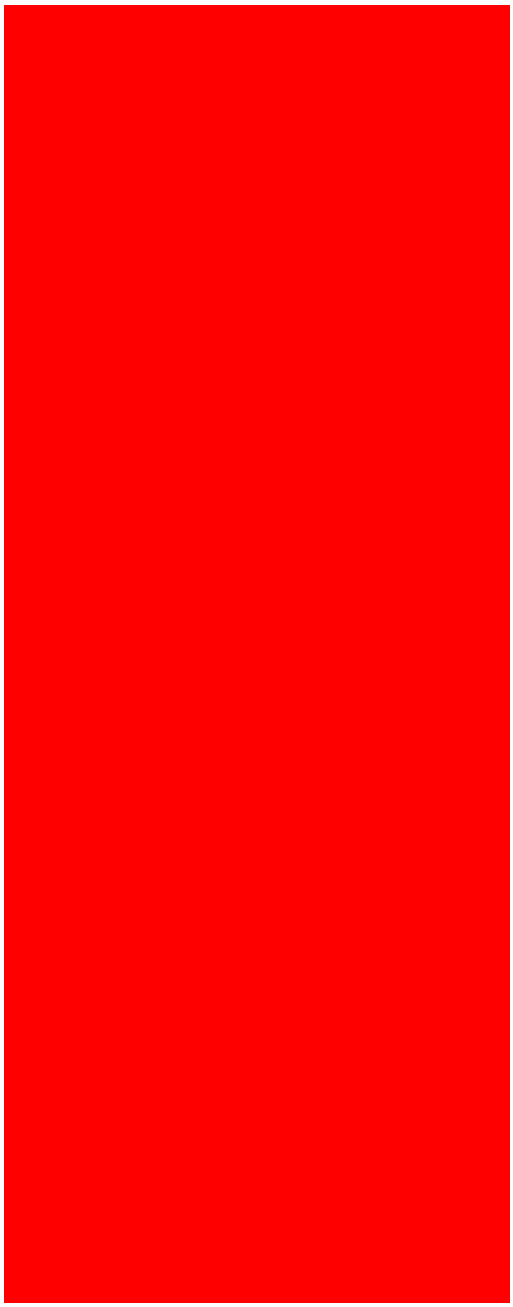
Aetna Better Health recognizes the value of a strong partnership with DHH and intends to maintain routine and ongoing communication regarding QAPI program activities. The table below outlines the mechanisms we propose to use to convey information to DHH regarding our QAPI program.

Communication with DHH regarding the QAPI Program

Method	Frequency	Description
QAPI Plan	Within 30 days of contract start	Plan and structure for QAPI program, according to DHH requirements.
QAPI Report	Annually	QAPI program activities and outcomes; Recommended new and/or improved QI activities; Evaluation of the impact and effectiveness of the QAPI program.
QM/UM Committee summary reports	Within 5 business days of each meeting	Description of agenda topics, summary of discussions, recommendations, interventions, and program outcomes.
Proposed PIP topics	Within 3 months after contract award and the beginning of each contract year thereafter	Outline of proposed PIP topics in accordance with DHH and CMS requirements.
PIP outcomes	Annually	Report of PIP outcomes as a result of implemented interventions, in accordance with DHH reporting specifications as detailed in the DHH Quality Companion Guide.
Ad hoc reports	Within 30 days of request	Submission of information as requested by DHH.

In addition to the methods for communication with DHH described above, Aetna Better Health's Quality Management/Utilization Management Committee will designate a member to participate in DHH's Quality Committee as required. This member will serve as a liaison for sharing information with DHH regarding our QAPI activities and provide pertinent information back to our QM/UM Committee.

90 J.6



J.6 Describe how feedback (complaints, survey results etc.) from members and providers will be used to drive changes and/or improvements to your operations. Provide a member and a provider example of how feedback has been used by you to drive change in other Medicaid managed care contracts.

Aetna Better Health understands that the most important information we can receive about our clinical and non-clinical programs, services, and processes comes from our members and providers. Members and providers are sources of critical information that will allow us to identify best practices or to improve/modify existing processes to help our members navigate the complex health care system, improve the accessibility and availability of services, and enhance quality of care. Aetna Better Health recognizes that driving change requires us to 1) educate members and providers about the communication tools we have available, 2) develop mechanisms supported by written policies and procedures for resolving member and provider concerns, 3) maintain systems tracking and trending this information, and 4) incorporate this information into our quality management structure to drive change resulting in enhanced member health outcomes, cost savings, and improved processes.

Aetna Better Health informs and educates members and providers on ways to contact us to provide feedback. We propose to use the following communication tools to inform our members and providers about how to submit feedback to us:

Member Communication	Provider Communication
Member Website	Provider Web Portal
Member Handbook	Provider Manual
Member Newsletters	Provider Newsletters
Case Management Department Personnel	Provider Services Representative (Toll free call)
Care Plan	Care Plan
Member Call Center (Toll free call)	Provider Service Center
UM/PA – Notice of Action Letter	UM/PA – Service Approvals/Denials

Member and Provider Feedback

Aetna Better Health welcomes member and provider feedback so we provide a number of vehicles for our members and providers to provide us with their comments, opinions, requests, and complaints. The points of member and provider contact with Aetna Better Health for feedback are identified and described below.

Member Feedback	Provider Feedback
Member Interactions with Health Plan personnel	Provider Satisfaction Survey
Member Grievances and Appeals	Provider Services Representative Contact
Consumer Assessment of Healthcare Providers and Subsystems (CAHPS®) surveys - Adult by service area	Provider Assistance Program for Non-Compliant Members

Member Feedback	Provider Feedback
Consumer Assessment of Healthcare Providers and Subsystems (CAHPS®) surveys - Child by service area	A Provider Claims Educator
Case Manager/Disease Manager	Provider Turnover
Health Education/Member Advisory Committee (HEMAC)	Provider Complaints and Appeals
Feedback to Member Services Representatives	Provider Site Visits
	Personnel Feedback
	Identifying and Coaching Physician Groups with High Panel Use of ER
	Provider Group Meetings

Member Feedback

Aetna Better Health recognizes that member feedback provides valuable input on our operational effectiveness in providing quality care to members. We maintain multiple opportunities for members to provide this information and to participate in system enhancements. Aetna Better Health incorporates member and provider feedback into our QAPI activities to drive operational changes and improvements that improve the quality of member care. Opportunities for members to provide feedback include:

- **Interactions with Health Plan Personnel** – Aetna Better Health uses every interaction with members to gather feedback on customer satisfaction and the quality of our services. We train every staff member who has telephonic and face to face interaction with members to: 1) use open ended questioning to elicit feedback and details; 2) restate what we hear to confirm we captured the individuals concerns appropriately; and 3) end every call with the question, "Is there anything else I can assist you with today". Our personnel then assist the member in resolving any other questions or concerns.
- **Member Grievances and Appeals** – Aetna Better Health uses the member grievance and appeals process to identify, assess, and address specific areas of member concern and dissatisfactions. These concerns and dissatisfactions can include issues with the health plan or its staff members or with providers who serve the membership. Aetna Better Health tracks and trends all expressions of dissatisfactions regardless of whether or not they are filed as a formal grievance or appeal including potential quality of care issues. This information serves to identify opportunities to initiate service improvement and corrective action activities that assist in meeting Aetna Better Health service standards and requirements.
- **Consumer Assessment of Healthcare Providers and Subsystems (CAHPS®) Surveys** CAHPS® surveys are a set of standardized member satisfaction surveys developed by the National Committee for Quality Assurance (NCQA) and the Agency for Health Care Research and Quality (AHRQ) to assess member satisfaction with the care provided by health plans. Process and protocol specified by the Healthcare Effectiveness Data and Information Set (HEDIS®[7]) are followed to produce standardized and comparable results.

[7] HEDIS® is a registered trademark of the National Committee for Quality Assurance.

Aetna Better Health conducts annual CAHPS® surveys to assess the quality and appropriateness of care to members in accordance with the following:

- Aetna Better Health contracts with a vendor that is certified by NCQA to perform CAHPS® surveys. This vendor performs CAHPS® Adult surveys, CAHPS® Child surveys, and the CAHPS® Children with Chronic Conditions survey.
- Survey results and a description of the survey process will be reported to the Department of Health and Hospitals separately for each required CAHPS® survey.
- The CAHPS® survey results will be reported separately for each Coordinated care Network (CCN) in each geographic service area (GSA) and provide valid and reliable data. The survey will be administered to a statistically valid random sample of clients who are enrolled with Aetna Better Health at the time of the survey.
- Analyses will provide statistical analysis for targeting improvement efforts and comparison to national and state benchmark standards.
- We will use the most current CAHPS® Health Plan Survey for Medicaid members which include:
  - ◊ Getting Needed Care
  - ◊ Getting Care Quickly
  - ◊ How Well Doctors Communicate
  - ◊ Health Plan Customer Service
  - ◊ Global Ratings
- Member Satisfaction Survey Reports will be submitted to Department of Health and Hospitals (DHH) within 120 days after the end of the plan year.

- **Member Surveys** – Aetna Better Health's Member Services Department will conduct telephone surveys from a random sample of members to: 1) survey members about their satisfaction with the quality and timeliness of services; 2) verify that the member actually received the service, which assists in the identification of potential fraud; and 3) measure whether transportation providers are meeting accessibility standards. The results of these surveys will be incorporated into Aetna Better Health's quality management processes to target system improvements.
- **Health Education/Member Advisory Council** – Aetna Better Health will promote our Health Education/ Member Advisory Council (HEMAC), which will be comprised of members who are representative of the membership and counties served by Aetna Better Health. The HEMAC will hold quarterly meetings and members will be actively involved in reviewing key member materials, survey results, annual reports, quality improvement activities and in suggesting areas for improvement in service delivery.

Provider Feedback

Aetna Better Health understands that provider feedback is valuable for identifying systemic or operational issues that need to be addressed to improve member care. Our personnel from all departments within the organization receives provider feedback through routine activities such as resolving provider complaints and appeals, provider monitoring visits, and care coordination activities. Our primary methods for receiving provider feedback are:

- **Provider Satisfaction –** Aetna Better Health's Provider Services Department conducts provider satisfaction surveys in coordination with Quality Management, and Administration support personnel. Practitioner and provider surveys assesses satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement, and utilization management processes, including medical reviews and support toward Patient Centered Medical Home implementation. The survey tool and methodology is submitted to DHH for approval prior to administration. An annual report that summarizes the survey methods and findings and provides analysis of opportunities for improvement will be submitted to DHH within 120 days after the end of the plan year. We will incorporate the results and analysis of the information into our quality improvement strategies that include but are not limited to performance improvement projects, medical record audits, performance measures and surveys.
- **Provider Assistance Program** – Aetna Better Health's Provider Assistance Program is designed to assist providers in managing care for high needs members who require additional supports. This innovative program facilitates the identification of potential barriers to members receiving care, and assists providers with member education and outreach. This process facilitates communication between Aetna Better Health and its providers while improving member care.
- **Provider Turnover** – Aetna Better Health's Provider Services personnel track and trend information regarding potential and actual provider turnover. This information is used to identify network and operational processes that may require improvement to reduce provider turnover and improve continuity of care for members.
- **Provider Complaints and Appeals** – Aetna Better Health Provider Services personnel document provider grievances in our call tracking system and track them through to resolution. Trended data regarding provider complaints and appeals are disseminated to the appropriate functional areas and reviewed by our QM/UM Committee who makes recommendations for interventions that improve the service delivery system and provider satisfaction.
- **Provider Site Visits** – Aetna Better Health's Provider Services personnel conduct routine on-site provider visits which afford them the opportunity to gather valuable provider feedback on our processes and their impact on member care and service delivery. Our personnel relay any provider feedback that requires action to the appropriate functional area.
- **Personnel Feedback** – Aetna Better Health's multi-disciplinary approach leads to personnel from multiple departments collecting provider feedback during routine activities (e.g., medical record reviews, EPSDT Coordinator visits, case management, authorization activities, and peer-to-peer discussions). Our personnel refer provider concerns or issues to the appropriate functional area for resolution and enter the information into our tracking system for trending.

Aetna Better Health tracks and trends the information provided by the venues described above and triangulate the data with other referenced sources to identify trends in provider feedback that may indicate a systemic issue. Aetna Better Health's Quality Assessment and Performance Improvement program (QAPI) provides the structure for analyzing, tracking, trending, and addressing issues identified through our member and provider feedback processes. We apply the

Plan-Do-Study-Act (PDSA) approach to our process for receiving, categorizing, analyzing, and acting upon feedback from both members and providers. Our PDSA approach involves leadership from throughout Aetna Better Health entire organization. Aetna Better Health's Board of Directors (the Board) has ultimate authority and responsibility for our Quality Assessment and Performance Improvement (QAPI) program. The Board provides strategic management direction to our QAPI program and evaluates the degree that the philosophy and scope of the QAPI program is incorporated within each operational/management unit and across Aetna Better Health's operations. The Board delegates responsibility for our QAPI program to the Chief Executive Officer (CEO). The CEO delegates day-to-day management responsibility and authority to the Chief Medical Officer (CMO). The CMO has responsibility, accountability, and authority for directing the development and implementation of the QAPI program. Our CMO has the support of our Aetna Medicaid Business Unit corporate care management, utilization management (prior authorization, concurrent review, retrospective review), Informatics, Information Technology (IT), Actuarial Services personnel to continually strengthen and improve our ability to develop, implement, monitor/evaluate, and replicate successful interventions to improve health outcomes and quality of care. Aetna Better Health's operational departments have responsibility for addressing specific member and provider issues as they arise. For instance, for member issues reported by members into the Member Services Department, the Member Services Manager is responsible for directing the process to identify, analyze, resolve, and report. For provider issues reported by providers into Aetna Better Health's Provider Services Department, the Provider Services Manager will be responsible for supervising the process to identify, analyze, resolve, and report. Other departments who receive member or provider feedback follow a very similar process. Our QAPI program receives feedback from our members and providers to continuously improve our programs, operations, and management approach. In our experience, these programs, operational, and management improvements lead to enhanced member health outcomes and efficiency of provider services.

Process to Drive Change or Improvements

Aetna Better Health understands that it is not just the information that is important but what we do with it, so we incorporate member and provider feedback into our QAPI activities to drive operational changes to improve clinical and non-clinical programs. Our operational departments have responsibility for addressing specific member and provider issues as they arise. The CEO and the CMO are responsible for the consistent, reliable, timely, and complete identification, analysis, resolution, and reporting of member and provider feedback trends to Aetna Better Health's Service Improvement Committee (SIC). The SIC is a multi-disciplinary committee chaired by the Chief Operating Officer and includes representatives from all functional areas within Aetna Better Health. This committee reviews complaints, and survey results to identify patterns and trends from Aetna Better Health's operational and medical departments. In addition to reviewing each report, the SIC evaluates whether the same themes appear across multiple data sources, thus allowing it to identify trends and prioritize improvement activities. The SIC reports its findings and recommendations related to monitoring activities to the Quality Management Oversight Committee (QMOC) which develops interventions, evaluates their success, and incorporates successful interventions into our QAPI program.

The QMOC is our principal forum to systematically identify, discuss, and resolve feedback, complaints, and survey results that impact both members and providers. The QMOC, chaired by

the Chief Executive Officer includes the following multi-departmental personnel: 1) Chief Medical Officer (CMO); 2) Chief Operations Officer (COO); 3) Chief Financial Officer (CFO); 4) Director of Quality Management (Quality Management Coordinator); 5) Director of Medical Management (Medical Management Coordinator); 6) Provider Services Manager; and the 7) Member Services Manager. This Committee reviews trended data, approves recommended intervention activities, identifies additional improvement activities, assigns action plans, and monitors the action plans to completion. The QMOC uses member and provider feedback, complaints, and survey results information to make recommendations regarding provider training, employee training, operational improvements, or policy changes. Through this committee, we make recommendations to manage and improve the network, track implementation on the QAPI action plan, and monitor each project through to completion.

Using member feedback to improve member satisfaction

Aetna Better Health's affiliated plans have successfully used member feedback to drive change in our service delivery systems. For example, based on trends identified from member grievances and transportation surveys, an Aetna Better Health affiliated plan, continually reviews all transportation delays and appointment/transportation no shows for quality of care referrals to the QM Department. The QM Department reviews each event to determine if it is appropriate to initiate a quality of care investigation. These investigations identified trends related to transportation delays affecting members on dialysis arriving timely for their scheduled appointments. In addition, our Member Services Department conducts telephone surveys based on a statistically significant random sample of members who requested transportation services the previous day. The purposes of the survey were to: 1) survey members about their satisfaction with the quality and timeliness of transportation services; 2) verify that the member actually received the service, which assists in the identification of potential fraud; and 3) measure whether transportation providers were meeting transportation time standards. As a result, the affiliated health plan's, QM/UM Committee reviewed the quality of care trends in conjunction with the Member Services Department transportation survey results and prioritized transportation needs for our members on dialysis for improvement. The QM/UM Committee recommended that the plan contract with a special transportation provider to improve transportation services for our members on dialysis. This intervention resulted in a significant reduction of transportation related potential quality of care concerns and improved member satisfaction as indicated through survey results.

Adding an additional transportation provider to our network resulted in a 5 percent reduction in transportation complaints from the previous year.

Using provider feedback to improve provider relations

Example 1

Aetna Better Health has utilized provider satisfaction survey results to identify specific opportunities for improvement and develop clearly defined corrective action plans to address them. We begin this process by closely monitoring key drivers of provider satisfaction and comparing our survey results in those areas with those of our competitors. We then establish specific goals for improvement over the coming year, delineate specific actions for achieving them, and designate a member of our management team as the responsible party for each action.

For example, one of Aetna Better Health's affiliated plans developed a goal to increase their scores in the area of Provider Services (e.g., timeliness in responding to questions or resolving problems; quality of the provider orientation process; distribution of information regarding quality improvement initiatives) by 3-5 percent. The percentage of providers rating this plan as excellent or very good in this category was 73-76 percent. Given the importance of the provider network to our success, the health plan believed that this score should be higher. To accomplish this objective, the health plan implemented the following actions:

- Initiated a monthly provider orientation session
- Conducted more frequent provider forums
- Began distributing Provider Newsletters more frequently

An additional topic for improvement was identified in the area of claims specifically related to the accuracy and timeliness of our claims processing and the resolution of payment problems or disputes. Although the health plan did not differ from its peers, the plan wanted to increase the percentage of providers reporting high levels of satisfaction with accuracy and timeliness of claims payment. Based on these results, the health plan initiated a regularly scheduled Provider Advisory meeting with the

Vice President of Claims and instituted a weekly Provider Relations meeting with the Claims Department personnel to afford providers the opportunity to voice their concerns and participate in resolving systemic issues.

Example 2

An Aetna Better Health affiliated plan, has successfully used provider feedback as an opportunity to create process improvements aimed at addressing issues of importance to providers. Based on feedback, the health plan re-designed Provider Services Department and developed various interdepartmental workgroups, each with the skills and authority necessary to resolve provider concerns in a timely and effective manner. These workgroups have been very effective in improving operations in response to provider concerns. Below is a description of the workgroups the health plan created to respond to provider feedback and how they have driven improvements in operations. Through the health plan's routine review of provider grievances, they identified the need to improve communication with providers related to claims payment. In response, the health plan developed a Health Plan Operations (HPO) Department that is responsible for claims research and resolution; reviewing product requirements and system configurations; managing provider records and encounter files; and reporting.

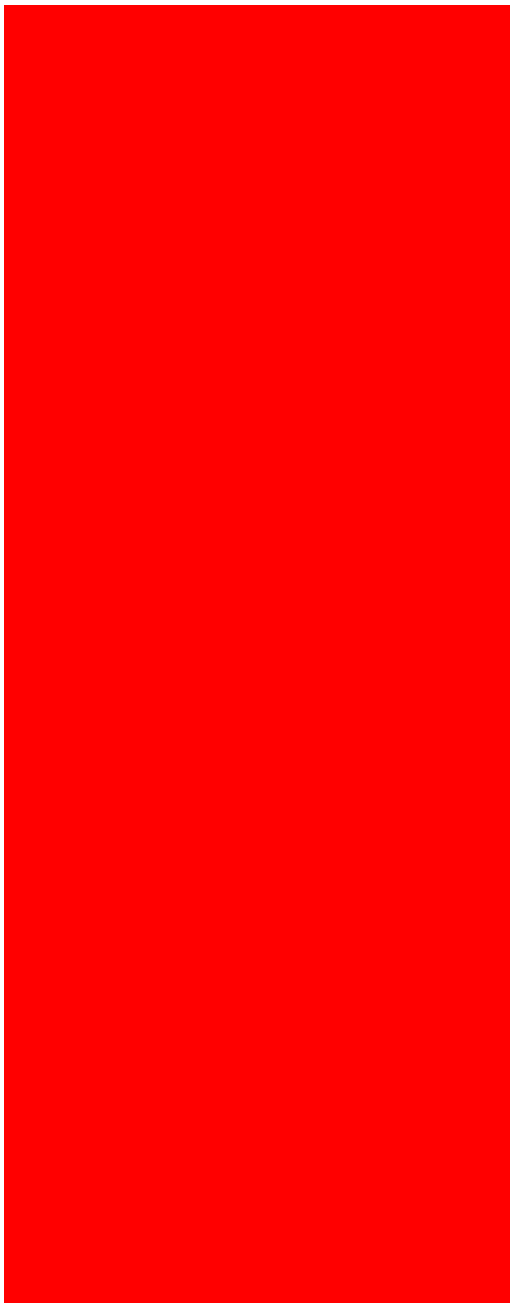
Our affiliated plan re-engineered the Aetna Better Health Provider Services Department to provide additional provider services personnel and a more organized focus on individual provider needs. The Aetna Better Health Provider Services Department includes a Vice President, Director, Managers, and Provider Services Representatives (PSRs) who support contracted providers. The health plan reassigned PSRs based on provider specialty designation rather than geographic location, giving them a better knowledge-base of regulatory requirements and payment considerations, claim trends that may occur in a given specialty, and understanding of physician practice patterns. In addition, the department includes dedicated personnel for network development and contracting, project management personnel to assist with business

planning, regulatory and internal reporting, and operations personnel to assist with higher level claim research projects and provider settlements.

PSRs keep in close contact with providers and visit Primary Care Provider (PCPs) a minimum of three times a year; obstetricians, and dentists twice a year; specialists once a year; hospitals and ancillary providers monthly. The health plan conducts additional ad hoc visits as necessary. PSRs encourage providers to discuss issues of individual concern with the goal of resolving them as they occur. For example, PSRs work with providers immediately upon learning that a provider may want to terminate their contract and actively address complaints or inquiries from providers. PSRs conduct appointment availability audits during visits and provide real-time education to noncompliant providers.

As a result of this approach, the health plan has experienced low rates of provider turnover, provider complaints, and noncompliance with appointment availability standards. The health plan's provider satisfaction scores are high and outperform the benchmark score for other Medicaid plans in the state of this example.

91 J.7



J.7 Provide, in Excel format, the Proposer's results for the HEDIS measures specified below for the last three measurement years (2007, 2008, and 2009) for each of your State Medicaid contracts.

- **If you do not have results for a particular measure or year, provide the results that you do have.**
- **If you do not have results for your Medicaid product line in a state where you have a Medicaid contract, provide the commercial product line results with an indicator stating the product line.**
- **If you do not have Medicaid HEDIS results for at least five states, provide your commercial HEDIS measures for your largest contracts for up to five states (e.g., if you have HEDIS results for the three states where you have a Medicaid contract, you only have Medicare HEDIS for one other state, provide commercial HEDIS results for another state).**
- **If you do not have HEDIS results for five states, provide the results that you do have.**
- **In addition to the spreadsheet, please provide an explanation of how you selected the states, contracts, product lines, etc. that are included in the spreadsheet and explain any missing information (measure, year, or Medicaid contract). Include the Proposer's parent organization, affiliates, and subsidiaries.**

Provide results for the following HEDIS measures:

- **Adults' Access to Preventive/Ambulatory Health Services**
- **Comprehensive Diabetes Care- HgbA1C component**
- **Chlamydia Screening in Women**
- **Well-Child Visits in the 3,4,5,6 years of life**
- **Adolescent well-Care.**
- **Ambulatory Care - ER utilization**
- **Childhood Immunization status**
- **Breast Cancer Screening**
- **Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care)**
- **Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents**

Include the Proposer's parent organization, affiliates, and subsidiaries

HEDIS®[8] Overview

Aetna Better Health is committed to maintaining a member-focused, innovative, and adaptable managed care system that provides the highest quality of care in an efficient and effective manner. We are a quality-driven, results-based organization that incorporates objective clinical

[8] HEDIS® is a registered trademark of the National Committee for Quality Assurance.

indicators (e.g. HEDIS measures) as an integral component of its Quality Assurance and Performance Improvement (QAPI) Program.

Aetna Better Health uses HEDIS performance measures as a key quality management/quality improvement tool, to monitor and measure our clinical performance using standardized specifications for quality, access, and utilization. Our QAPI Program provides the framework for the planning, implementation and monitoring of all processes that contribute to the organization's ability to maximize program efficiency, effectiveness, and responsiveness; limit operational costs and improve member access and satisfaction. We incorporate HEDIS data into our QAPI program to 1) track and monitor performance and quality of care at the aggregate and individual provider and member level; 2) identify opportunities for improvement; 3) measure the successful implementation of interventions or corrective actions; and 4) evaluate our effectiveness in meeting our QAPI program goals. Aetna Better Health tracks performance measure results on a monthly basis, using NCQA certified HEDIS software to generate monthly population- specific reports that show our progress year to date (using a 12 month rolling period for our administrative data). We compare our annual and monthly performance measures results to population established minimum performance standards, NCQA percentiles, our own performance goals and goals such as those specified by the Department of Health and Hospitals (DHH). In this way, we are able to identify opportunities for improvement as well as best practices within Aetna Better Health's affiliated plans that can be shared with all of our programs to improve member health outcomes. Through these ongoing monitoring and trending processes we are able to implement interventions in a timely manner to address any identified opportunities for improvement. Our processes are iterative and integrated throughout the organization, demonstrating a company-wide commitment to quality care.

For Aetna Better Health, quality management is a company-wide endeavor, integrated by interdepartmental monitoring processes and activities business application systems and databases that are accessible to all areas. The quality program for each of Aetna Better Health's affiliated plans includes a structure of oversight committees with representation not only from across Aetna Better Health but from the provider network and member population as well. Functional program areas and all our formal committees actively participate in identifying opportunities for quality improvement identified through our review of HEDIS performance measures. The foundation of Aetna Better Health's processes is to enhance and implement our QAPI opportunities and interventions by establishing, reinforcing, and facilitating a cross-functional approach through leadership from our senior management team and consistent internal communication about QAPI activities through the committee structure.

Aetna Better Health's Board of Directors (the Board) has ultimate authority and responsibility for our Quality Assessment and Performance Improvement (QAPI) program. The Board delegates responsibility for our QAPI program to the Chief Executive Officer (CEO). The CEO delegates day-to-day management responsibility and authority to the Chief Medical Officer (CMO). The CMO has responsibility, accountability, and authority for directing the development and implementation of the QAPI program, including the review of HEDIS data. The Quality Management/Utilization Management Committee (QM/UM) chaired by the CMO, serves as an integrating forum where key personnel from all functional areas within the organization

systematically review HEDIS and other data to identify opportunities for improvement and make recommendations for system enhancements that lead to positive member outcomes.

Aetna Better Health has a strong track record of routinely generating and using HEDIS measures to improve member health outcomes, identifying opportunities for improvement, and creating system efficiencies that result in cost-savings. For example, our HEDIS data related to well-child visits consistently score above established benchmarks and NCQA percentiles in response to initiatives we have implemented to improve access to EPSDT services across all Aetna Better Health's affiliated plans. Similarly, HEDIS rates for adolescent and adult access to preventive care have steadily climbed as have rates for timeliness of prenatal and postpartum care, demonstrating our commitment to maintaining a health care delivery system in which members receive the right care in the right place at the right time. We will bring this same commitment to providing appropriate, accessible care in serving our Louisiana Medicaid members.

HEDIS Description

The HEDIS measures included in the attached spreadsheet represent data from our Medicaid programs similar in population and scope to the Louisiana population we are proposing to serve. Specifically, our California, Missouri, and Delaware plans serve members eligible through the TANF and CHIP programs with a large portion of their memberships being comprised of children who present with issues similar to those experienced in Louisiana. Best practices implemented in these states to drive HEDIS measures can be applied to the members we will serve in Louisiana, thus improving health outcomes for members in that program. Our Maryland affiliate serves members eligible through TANF and CHIP as well as members who are eligible through the acute, blind and disabled (ABD) program, which is the population served by our largest affiliate in Arizona. As the Louisiana program serves members in each of these groups (TANF, CHIP, ABD), the data presented from each of these plans is consistent with what we will be able to collect and report on upon contract award. Finally, Aetna Better Health is proud to be able to present data for our Connecticut affiliate beginning in 2009. This health plan began serving members in August 2008, so HEDIS data is not available for 2007 and 2008. The positive HEDIS results for our Connecticut health plan reflect Aetna Better Health's ability to leverage its considerable resources to positively impact member care in a short period of time.

Aetna Better Health generates HEDIS measures in accordance with each state's requirements and NCQA standards. States may add or delete measures throughout the course of our contract, so for some HEDIS measures, data is not available for each of the three years requested. HEDIS results for Weight Assessment and Counseling for Nutrition and Activity in Children and Adolescents are only available for Delaware for SFY 2008 and 2009 as this measure was released in 2008. Finally, we included data from our commercial Louisiana PPO product when data were unavailable for five Medicaid plans. Aetna Life Insurance Company is not licensed to sell health insurance in the state of Louisiana, but serves "national account" business. As requested, we have presented a table of our HEDIS results below.

Aetna HEDIS Measures 2007-2009

Adults' Access to Preventive/Ambulatory Health Services(20-44)					
2007		2008		2009	
State	Results	State	Results	State	Results
AZ	79.9%	AZ	83.3%	AZ	84.4%
DE	86.6%	DE	88.1%	DE	89.1%
MD	74.4%	MD	79.0%	MD	81.7%
CT	NA	CT	NA	CT	81.8%
LA-PPO	91.9%	LA-PPO	92.5%	LA-PPO	92.8%
Our Connecticut affiliate acquired its Medicaid contract in 2008, therefore, data for this measure is available going forward from then. Note: LA PPO results are based on administrative data only.					
Adults' Access to Preventive/Ambulatory Health Services(45-64)					
2007		2008		2009	
State	Results	State	Results	State	Results
AZ	86.9%	AZ	88.3%	AZ	89.1%
DE	90.4%	DE	92.2%	DE	92.8%
MD	85.0%	MD	87.5%	MD	87.3%
LA-PPO	95.5%	LA-PPO	95.9%	LA-PPO	96.2%
The plans represented in this HEDIS measure serve a sufficient number of adults to calculate accurate results. The number of adults served by our other Medicaid programs was insufficient to calculate accurate results for this measure.					

Timeliness of Prenatal Care					
2007		2008		2009	
State	Results	State	Results	State	Results
DE	81.7%	DE	88.2%	DE	88.2%
MD	84.0%	MD	87.0%	MD	89.7%
MO	91.1%	MO	92.1%	MO	95.8%
AZ	83.9%	AZ	83.8%	AZ	85.0%
CT	NA	CT	NA	CT	84.9%
LA-PPO	48.6%	LA-PPO	49.6%	LA-PPO	54.5%
Our Connecticut affiliate acquired its Medicaid contract in 2008, therefore, data for this measure is available going forward from then.					
Well-Child Visits in the 3,4,5,6 years of life					
2007		2008		2009	
State	Results	State	Results	State	Results
CA	80.8%	CA	80.8%	CA	85.8%
DE	73.6%	DE	79.3%	DE	76.7%
MD	79.1%	MD	73.1%	MD	85.7%
AZ	70.1%	AZ	71.1%	AZ	73.2%
CT	NA	CT	NA	CT	73.5%
LA-PPO	39.8%	LA-PPO	42.4%	LA-PPO	47.5%
Our Connecticut affiliate acquired its Medicaid contract in 2008, therefore, data for this measure is available going forward from then.					

Childhood Immunization Status - Combo 3					
2007		2008		2009	
State	Results	State	Results	State	Results
DE	76.6%	DE	76.6%	DE	75.2%
MD	67.8%	MD	70.1%	MD	76.2%
MO	67.9%	MO	66.2%	MO	66.7%
AZ	83.5%	AZ	NA	AZ	78.8%
LA-PPO	25.0%	LA-PPO	26.5%	LA-PPO	24.9%
AZ rates for this measure are calculated every other year by the state Medicaid program; this measure was not calculated in 2008.					

Comprehensive Diabetes Care- HgbA1C component					
2007		2008		2009	
State	Results	State	Results	State	Results
DE	78.18%	DE	78.47%	DE	78.10%
MD	78.39%	MD	74.16%	MD	78.59%
AZ	NA	AZ	83.75%	AZ	83.37%
MO	NA	MO	NA	MO	83.22%
CT	NA	CT	NA	CT	79.56%
LA-PPO	67.3%	LA-PPO	71.4%	LA-PPO	73.6%
Our Connecticut affiliate acquired its Medicaid contract in 2008, therefore, data for this measure is available going forward from then. MO did not have a sufficient number of members that met the criteria for this measure. For AZ, this measure was not calculated by the state in 2007.					

Adolescent well-Care					
2007		2008		2009	
State	Results	State	Results	State	Results
CA	61.74%	CA	63.41%	CA	67.78%
DE	41.67%	DE	51.82%	DE	46.47%
MD	51.33%	MD	49.54%	MD	64.72%
MO	49.54%	MO	43.1%	MO	44.21%
AZ	NA	AZ	45.43%	AZ	45.24%
CT	NA	CT	NA	CT	51.09%
LA-PPO	27.8%	LA-PPO	29.2%	LA-PPO	33.5%
Our Connecticut affiliate acquired its Medicaid contract in 2008, therefore, data for this measure is available going forward from then. For AZ, this measure was not calculated by the state in 2007.					

Breast Cancer Screening					
2007		2008		2009	
State	Results	State	Results	State	Results
AZ	61.0%	AZ	63.8%	AZ	65.7%
DE	53.6%	DE	53.2%	DE	55.3%
MD	45.6%	MD	46.2%	MD	44.5%
LA-PPO	66.8%	LA-PPO	68.4%	LA-PPO	69.8%
The plans represented in this HEDIS measure serve a sufficient number of adults to calculate accurate results. The number of adults served by our MO and CA programs was insufficient to calculate accurate results for this measure.					

Timeliness of Postpartum care					
2007		2008		2009	
State	Results	State	Results	State	Results
DE	59.8%	DE	70.6%	DE	67.2%
MD	60.3%	MD	62.1%	MD	72.2%
MO	70.8%	MO	67.2%	MO	68.0%
AZ	58.1%	AZ	83.82%	AZ	65.5%
LA-PPO	40.7%	LA-PPO	37.8%	LA-PPO	35.5%
Chlamydia Screening in Women					
2007		2008		2009	
State	Results	State	Results	State	Results
AZ	51.8%	AZ	55.6%	AZ	57.9%
CA	63.5%	CA	65.1%	CA	71.0%
DE	64.8%	DE	66.9%	DE	66.9%
MD	60.5%	MD	61.1%	MD	63.0%
CT	NA	CT	NA	CT	63.1%
LA-PPO	28.7%	LA-PPO	32.0%	LA-PPO	32.6%
Our Connecticut affiliate acquired its Medicaid contract in 2008, therefore, data for this measure is available going forward from then.					
Weight Assessment and Counseling for Nutrition and Activity in Children					
2007		2008		2009	
State	Results	State	Results	State	Results
DE	NA	DE	49.88%	DE	36.50%